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VOL. 70, NO. 1 JANUARY 1985

THE NEBRASKA MEDICAL JOURNAL

117 Years

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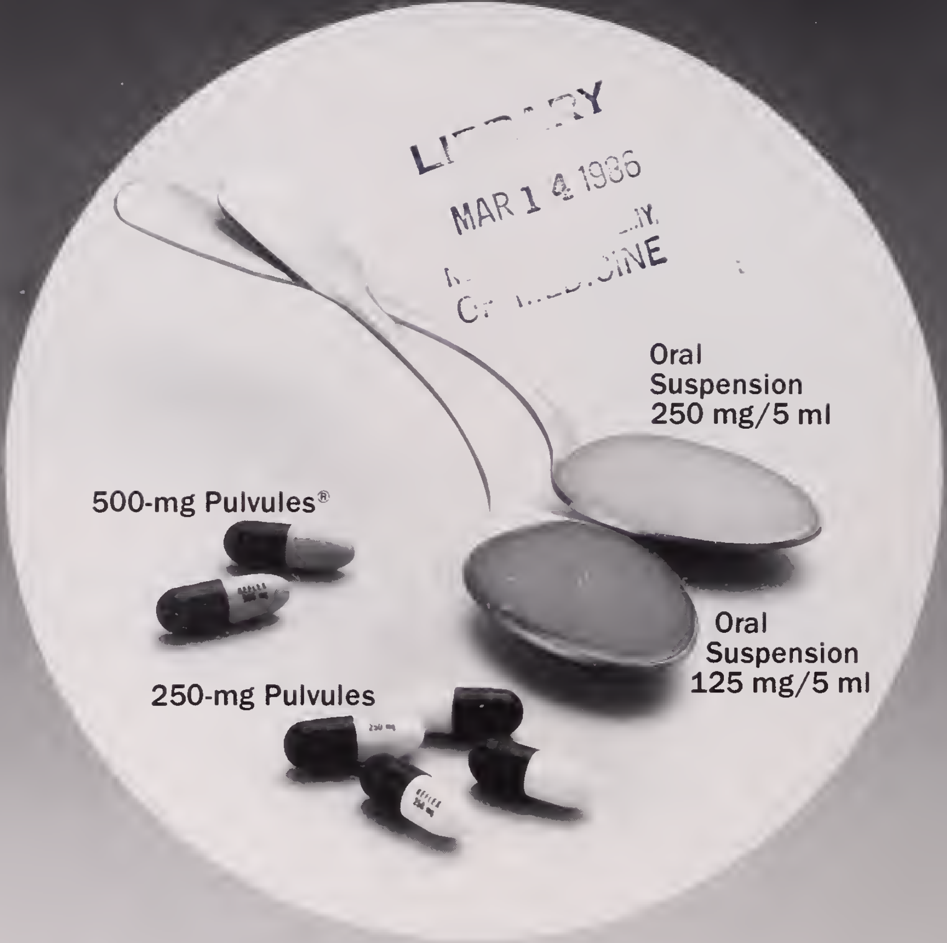

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117th Annual Session, Nebraska Medical Association

April 26-29, 1985

NEBRASKA ALLERGY SOCIETY

The objective of this course is to review current controversies regarding the treatment of asthma. This will include the use of theophylline and metaproteranol.

MISSOURI VALLEY DERMATOLOGIC SOCIETY

The diagnosis and treatment of common dermatologic problems which would be encountered by the practicing clinician will be presented and divided into three areas. These areas will include pediatric dermatology, dermatologic surgery and common dermatoses; the focus of the discussions will be toward the practical approach to cutaneous entities in each of these categories.

NEBRASKA HEART ASSOCIATION, LINCOLN DIVISION, and the NEBRASKA CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

This course is designed to review both cardiac and pacemaker arrhythmias with emphasis on diagnosis and treatment. In addition, cost effective evaluation of dysrhythmias as well as pacemaker indications will be presented. There will be discussion on pharmacologic agents as well as drug interactions. This course is aimed at both primary care and subspecialty physicians who deal with cardiac patients.

NEBRASKA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

The objective of this course is to update the primary care physician in areas of adolescent medicine.

NEBRASKA ACADEMY OF OPHTHALMOLOGY

The general topic of this course will be Strabismus. The speaker will be William E. Scott, M.D., Professor of Ophthalmology, Department of Ophthalmology, University of Iowa Hospitals and Clinics, Iowa, City, IA.

NEBRASKA RADIOLOGICAL SOCIETY

Short scientific papers will be presented by residents and staff of the University of Nebraska Medical Center Department of Radiology.

NEBRASKA CHAPTER, AMERICAN COLLEGE OF SURGEONS

This course is designed for Candidates and Fellows of the American College of Surgeons to act as a forum for presentation of papers of current interest.

NEBRASKA MEDICAL ASSOCIATION AUXILIARY

The Auxiliary-sponsored portions of the Annual Sesion will include its Annual Board Meeting on Friday morning, a progressive dinner Friday evening, the brunch and presentation of awards Saturday morning, a meeting of the Gavel Club Friday afternoon, and the meeting of the new Board on Sunday.

Additional programs are in the planning stage and will be announced well in advance of registration dates. Reserve April 26-29 now to take part in this outstanding program. All meetings and programs will be held at the new Cornhusker Hotel in Lincoln.

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Review articles will be considered, and should generally be limited to less than 4,000 words and approximately 30 references.

Manuscripts describing original clinical or laboratory research should be limited to 2,000 words and approximately 20 references.

Acknowledgements must be given when material from other publications is included. Provide names of authors, title of article, title of journal or book, volume number, pages, month and year, and publisher's permission to reprint.

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116th Annual Session
April 26-29, 1985

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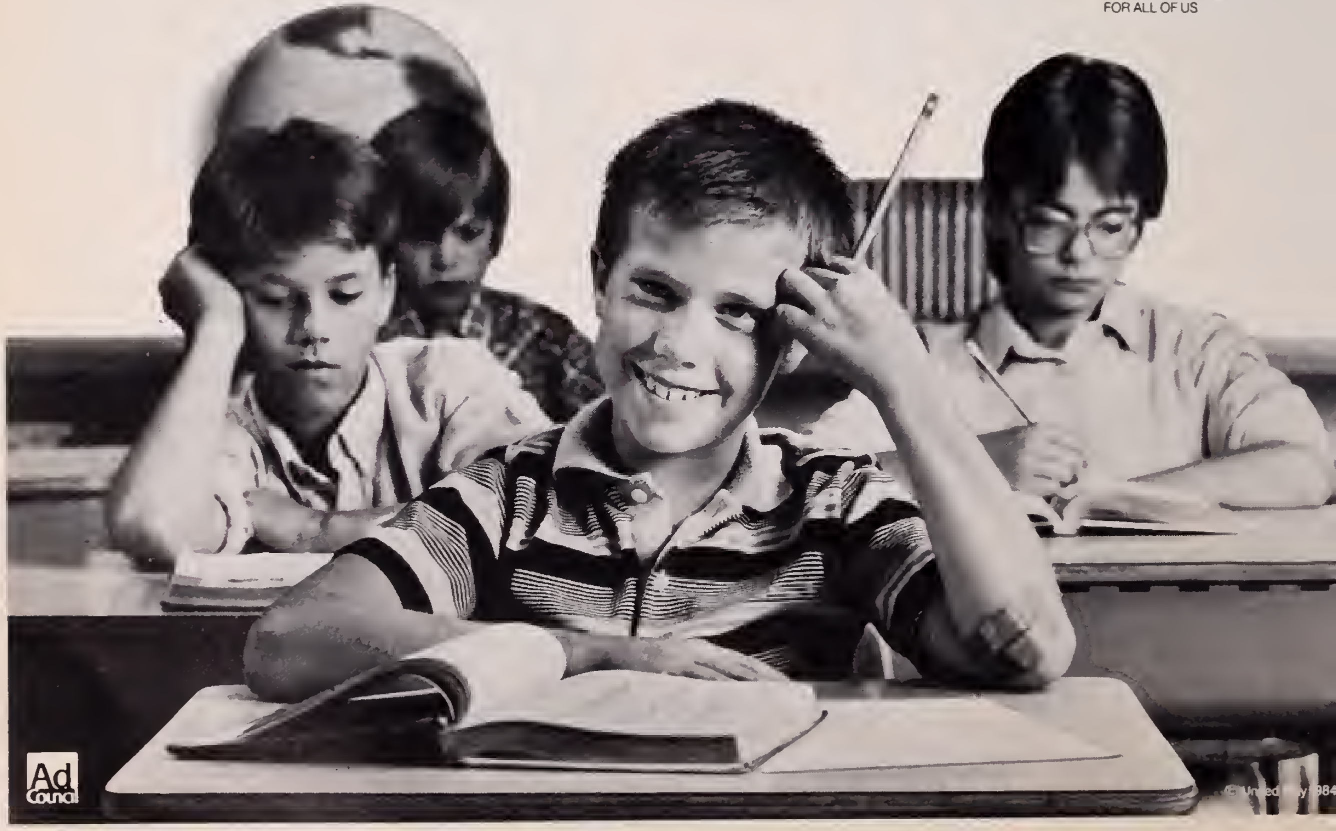

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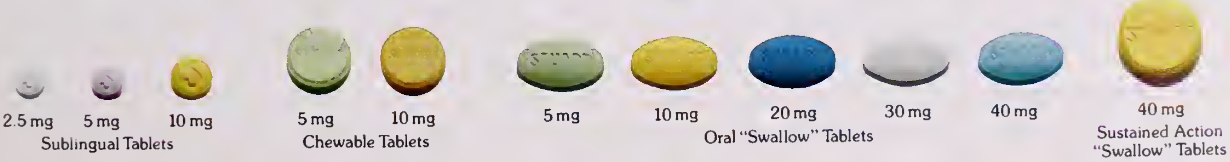

See following page for brief summary of prescribing information.

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg) Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2 5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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STR-2282

WashingtoNotes

White House Also Nixes Technology Council

In a tersely worded message to Congress, President Reagan warned that he would not request funding for the new Council on Health Care Technology, a quasi-private clearinghouse for technology assessment.

Although Reagan signed S771, which authorized the Council, he noted "strong objection" to the constitutionality of the group.

Under the bill, passed earlier this month by Congress, the Council would collect information about specific health care technologies, promoting some and discouraging others. It would be composed of members chosen by the federal Department of Health and Human Services and the private National Academy of Sciences, including federal officials, members of the general public, and representatives of the fields of medicine, law, ethics, economics and management.

Reagan contended that the council would mix governmental and non-governmental, executive and legislative elements "in a manner which is inconsistent both with the constitution and with sound government practices."

Because the Council would perform government duties, it is unconstitutional for its members to be selected by a nongovernmental agency, he noted.

The President asked Congress to go back to the drawing board, revamping the structure and function of the Council. Until such remedial legislation, he will refuse to ask for funding in his January budget. However, Congress could override this deferral, if it wished.

* * *

Non A - Non B Hepatitis Virus Found

Food and Drug Administration scientists have identified a third virus of hepatitis. Until now this was called non-A non-B since it was known that the virus not either hepatitis A of hepatitis B virus. Until now, however, there

(Continued on page 28)

THE NEBRASKA MEDICAL JOURNAL

'Stable Government Policies Needed'

'Parallels' Between Medicine, Agriculture

JERALD R. SCHENKEN, M.D.

The writer, an Omaha doctor, is a board member of the Greater Omaha Chamber of Commerce and was chairman of a recent chamber delegation that went to Washington to promote agriculture.

AFTER World War II, America experienced unusual economic growth. Rising world markets for agricultural and agri-business products, increased availability of money for farm loans, rising profits from agriculture and agri-business, federally mandated price supports in certain sectors of the agricultural economy, rapidly rising farmland values, increasing purchase of land for speculation by a broad sector of the economy and the many governmental policies promoting agriculture all sent consistent, positive signals to farmers, ranchers and businessmen that said loud and clear: expand, produce and sell.

What about medicine? During the same period, the Hill-Burton Act was passed providing funds for building hospitals in communities throughout the nation. Private health insurance coverage, almost non-existent before World War II, expanded rapidly. Labor-management contracts through the collective bargaining process almost always focused on improved health benefits.

The federal government provided substantial tax breaks for employer-provided health and disability benefits. In 1965, Congress approved the Medicare act, dedicated to assuring availability of medical care to the elderly and poor. Finally, the end-state kidney disease program was added, paying for the care of tens of thousands of Americans.

These signals were also heard by physicians, educators, other health professionals and business: expand facilities, technology and personnel to make available to the public, at unprecedented rates, these many high-quality services.

What was the response? In agriculture, production increased, farmers and ranchers began buying land at higher prices and adding movable equipment such as tractors and combines as well as center-pivot irrigation, allowing them to make land more productive with less manual labor.

The response in health was no different. Through massive public and private efforts, the number of physicians and other health professionals was greatly increased. Hospitals expanded in numbers and size. A dramatic increase in technology occurred, unparalleled in the history of medicine. Heavy capital investment occurred. Services, costs and charges all increased rapidly. And in addition, all the various industries that grew up to service this health economy — the insurers, drug companies, technology companies and food services, to mention a few — expanded to respond to this demand.

What was the result? In agriculture, more and better farm products became available. Wholesale and retail prices were lower. Farm income for most increased, at least for a while.

Unfortunately, the government continued its efforts to solve problems as it had in the past with price supports (supply control). Reserve programs assured supply at tax-supported low cost while supporting farm income.

What about health? The nation's health, by any measure that we use, has never been better. Access to more specialized medical care was greatly improved. This improvement occurred, however, with substantial cost. The percentage of GNP allocated to health rose to more than 11 percent. Most physicians' incomes increased. The response of government was to try to control costs by regulation, given the public's expanded appetite for health care and an apparent oversupply of physicians and hospitals.

There have been no villains in this scene. Everyone involved was responding to the incentives operative at the time, given the information they had available and the needs of the public. This includes all of us, farmers and consumers, physicians and patients, voters and the government. The real question is what can and should we do about it now?

The answer is tied to the personal involvement of all concerned. There should be a stable government policy, not necessarily distorted by changing administrations, that will allow the farmer and the physician to adapt positively to the changing desires of the customers and the patients. And most importantly, the customers for agricultural products and the patients needing medical care must take increased responsibility as we all participate in the solution.

Practical differences between farming and medicine of necessity make specific solutions quite different. Farmers should be given the opportunity to increase both production and profits. Credit at a reasonable rate for both the farmer and the agri-business community must be available. The role of government should be one of facilitator and not manipulator. It should help to open doors for foreign trade and encourage research that benefits both farmer and consumer.

In health, physicians and patients alike must share responsibility for change. Healthy lifestyles prevent disease and save money. Physicians must continue to encourage weight and blood pressure control, and patients must listen and respond. Cigarettes have got to go!

Insurance must be redesigned to include appropriate deductibles and co-insurance that encourage patients to be prudent in their use of medical services while not discouraging them from acquiring needed care. Physicians must be sensitive to the cost of care and work with their patients to assure that their charges are reasonable and the services provided are needed.

The several solutions I have proposed for both agriculture and medicine are very general. Much more detailed suggestions have been made elsewhere. I have given several examples to give a flavor of where I feel we should go.

Yes, there are great parallels between agriculture and medicine. We have been very fortunate in Nebraska in having excellence of both. We must all continue to work together to make sure that this is continued.

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The Role of Computed Tomography in Blunt Trauma

Presented at the American College
of Surgeons Meeting
Nebraska Medical Association
Meeting, April 1984

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TRAUMA is the third leading cause of death in this country today with approximately 10% of deaths being secondary to abdominal injuries and 25% related to chest injuries.[1] In blunt trauma accurate and rapid identification of abdominal and thoracic injuries is necessary for appropriate treatment. Traditionally, the initial evaluation of the trauma patient has involved physical examination, laboratory tests, peritoneal lavage, and conventional radiography. With the development of computed tomography (CT), another tool has been made available for evaluating the condition of patients with blunt trauma. There have been recent reports in the literature describing the effectiveness of CT in the management of blunt abdominal injury.[2, 3] We reviewed our experience with 10 patients sustaining blunt trauma to determine the role of CT in managing the abdominal and chest injuries.

Materials and Methods

We reviewed the experience with patients who sustained injuries secondary to blunt trauma during a 12 month period. All patients underwent CT of the abdomen within 24 hours of admission. There were 7 males and 3 females with age ranging from 15 years to 69 years (mean 37.5 years). The records of each patient were reviewed to determine the injuries incurred, diagnostic studies employed, results of CT examinations and operations performed. Computed tomography was performed using GE CT-8800 or GE CT-9800 with 10mm slices at 10-20mm intervals. Oral and intravenous contrast agents were administered at the discretion of the radiographer.

Results

All 10 patients had CT of the abdomen. In addition, three of the patients underwent CT of the chest and two other patients underwent CT of the head in conjunction with the abdominal scans. Seven abdominal and two thoracic injuries were identified by CT scan. These included: three intrasplenic injuries, two liver injuries, a retroperitoneal hematoma and a perirenal hematoma. Tables I and II summarize the CT and operative findings.

Based on CT results, 5 patients were managed operatively and 5 patients were managed non-operatively. All patients managed non-operatively had normal CT scans, except one patient (Figure 1) whose CT scan revealed a probable splenic hematoma and fluid in Morrison's pouch.

Three celiotomies and two thoracotomies were performed on the patients managed operatively. Operation was delayed by CT findings in one patient. Twelve hours after admission the patient became hypotensive and peritoneal lavage was performed which was positive. At operation a splenic hilar injury was identified requiring splenectomy. CT failed to demonstrate a pancreatic capsular tear and retroperitoneal hematoma which were found at operation in another patient.

Quantitation of intraperitoneal fluid by CT was estimated in 3 patients. Intra-abdominal fluid was estimated as a small amount in one patient, 100-200cc in a second patient and was noted but not quantified in a third patient. At

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TABLE I
PATIENTS MANAGED NONOPERATIVELY

CASE	MECHANISM	INJURIES	CT RESULT	COMMENT
D.B. 20 yr. F	MVA *	Cerebral contusion fx: T9-10 with paraplegia	Abdomen: normal	
R.S. 18 yr. M	MVA	---------	Abdomen: normal	Splenic injury ruled out
B.T. 23 yr. M	MVA	Splenic hematoma scalp laceration	Abdomen: probable splenic hematoma, fluid Morrison's pouch	
W.B. 41 yr. M	Assault	Rib fractures: left 6-11, pelvic fracture	Abdomen: normal	
G.W. 41 yr. M	MVA	Closed head injury skull fracture, scalp avulsion, fracture left ulna	Abdomen: normal	

*Motor Vehicle Accident

TABLE II
PATIENTS MANAGED OPERATIVELY

CASE	MECHANISM	INJURIES	CT RESULT	OPERATION
P.S. 22 yr. F	MVA *	Laceration liver, laceration spleen, multiple rib fractures, fracture left acetabulum, multiple extremity fractures	Abdomen: laceration liver, laceration spleen, intraperitoneal blood, retroperitoneal hematoma	Celiotomy: 500 cc blood small laceration spleen, stellate laceration liver
E.P. 69 yr. M	MVA	Laceration spleen, left rib fracture	Chest: mediastinal hematoma, pneumothorax Abdomen: subcapsular hematoma spleen	Celiotomy: gross blood, bleeding splenic hilum
C.O. 15 yr. M	Sledding Accident	Liver laceration, capsular tear head of pancreas, retroperitoneal hematoma	Abdomen: contusion right lobe liver and right kidney 100-200cc fluid	Celiotomy: 1000 cc blood, bleeding liver laceration, pancreatic capsule tear, retroperitoneal hematoma
R.L. 62 yr. F	Fall down steps	Multiple rib fractures left, tear 2nd left intercostal artery, pelvic fracture	Chest: rib fractures hemothorax Abdomen: left perinephric hematoma	Thoracotomy: laceration 2nd left intercostal artery
J.A. 69 yr. M	Thrown from horse	Thoracoabdominal aorta dissection, pneumothorax, fracture ribs 2-4 right	Chest: aortic aneurysm at origin left subclavian Abdomen: solid organs normal	Thoracotomy: repair of thoracic aneurysm

*Motor Vehicle Accident

operation, the amount of intraperitoneal blood was greater than estimated by CT scan in each case. The first patient with a small amount of fluid by CT scan had 1000cc of blood in the peritoneal cavity. The second patient with 100-200cc of fluid by CT scan had 300-400cc of blood intra-abdominally. The third patient with intraperitoneal fluid noted by CT scan had 500cc of blood in the abdomen at operation.

In those patients undergoing thoracotomy, CT scan was helpful to rule out significant injury to solid abdominal organs and retroperitoneal structures.

Seven patients had additional radiographic studies performed while in the Radiology Department. The time in Radiology ranged from 30 minutes to 155 minutes, depending on the number of radiographic procedures performed. Accurate determination of the time required to perform the CT scans themselves could not be done.

Discussion

Trauma is the leading cause of death during the first few decades of life in this country. Prompt and accurate identification of abdominal and thoracic injuries is important in providing appropriate and timely therapy. In a review of the literature Powell et al[4] reports an accuracy rate of only 65.5% when assessing acute intra-abdominal injury by clinical examination. Diagnostic peritoneal lavage has an accuracy of 90-97%.[5] DuPriest and co-workers report that 26% of injuries diagnosed by peritoneal lavage need no repair at the time of laparatomy.[6] No doubt diagnostic peritoneal lavage has lead to a decrease in mortality from blunt trauma; however, as pointed out by Soderstrom and others,[7] diagnostic peritoneal lavage is invasive, non specific for organ injury, and fails to evaluate the retroperitoneum. Complications of this procedure include bowel perforation, laceration of blood vessels and bladder injury.[4] Equivocal and false positive tests are a problem, as they may result from traumatic insertion of the lavage catheter, or retroperitoneal and pelvic injuries that allow hemorrhage into the peritoneal cavity. For these reasons diagnostic peritoneal lavage may lead to an unnecessary operation.

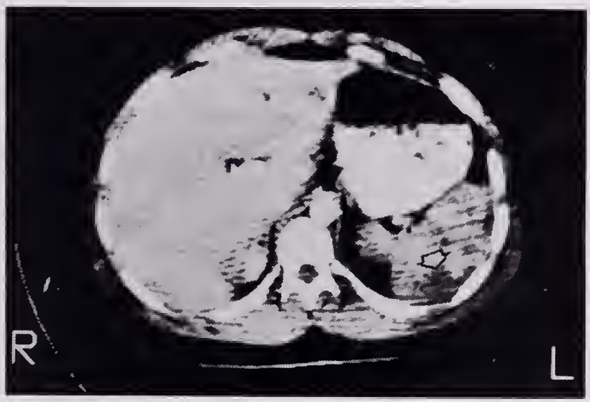

Figure 1
CT Scan showing splenic hematoma in patient treated nonoperatively.

CT has several advantages compared to peritoneal lavage. CT is better suited for evaluation of retroperitoneal trauma including pancreatic, duodenal and renal injuries. CT is non-invasive; and unlike peritoneal lavage, CT is able to determine solid organ injuries and distinguish parenchymal hematomas from lacerations. CT scanning can often be performed in a more timely fashion than peritoneal lavage if fluid analysis is required. Once the patient is positioned in the CT scanner, the study can be completed in 15 minutes. However, image reconstruction requires approximately 30 minutes. However, there are some limitations to CT. To avoid false positive results, it is necessary to perform CT prior to diagnostic peritoneal lavage. CT is limited by motion artifact, internal devices (NG tube, hemoclips) and external devices (splints, spinal boards). At our institution, the cost of this CT scan is $450.00 and peritoneal lavage costs $175.00.

Federle and colleagues[3] report a 99% accuracy rate of CT scan in 200 patients with blunt abdominal trauma. In our patient group, three splenic injuries were identified by CT. Two injuries were confirmed at operation and one injury was managed non-operatively. Federle et al[3] reports CT correctly identified 49 of 50 patients evaluated for splenic injury. In one patient motion artifact gave a false negative result. Moon and Federle report 25 patients with hepatic injury identified by CT scan.[8] Ten of 25 patients underwent operation based on CT scan and 25 patients were managed non-operatively. Both liver injuries were identified by CT scan in our patient group.

Hemoperitoneum was identified by CT scan in 3 patients in our study group. There was no correlation between the amount of intra-abdominal fluid estimated by CT scan and the amount of blood found at the time of operation. To what extent ongoing blood loss occurred cannot be accurately identified by CT scan. Federle and Jeffery report 56 patients with hemoperitoneum identified by CT scan.[9] Thirty-seven patients in this series underwent laparotomy and hemoperitoneum was demonstrated in all 37 patients. Attempts to correlate CT estimates of peritoneal blood with the amount of intraperitoneal blood found at operation were unsuccessful.

The role of CT scan in the management of chest trauma is uncertain because conventional radiographic methods are usually able to identify significant injuries. Indications for chest CT scan in our study group were widened mediastinum, massive hemothorax and suspected dissecting thoracic aneurysm. An arteriogram was precluded because of anuria in a patient with a thoracic aneurysm. The amount of intra-arterial contrast needed was prohibitive and less contrast material could be administered by using CT scan.

Several authors have recommended protocols for the use of CT examination in the management of blunt abdominal trauma.[3, 10] CT should be considered in patients with stable vital signs and suspected intra-abdominal injury. It is especially useful when there are concomitant central nervous system injury, suspected retroperitoneal injury, pelvic fractures with hemorrhage and other injuries requiring operation with a general anesthetic. CT scan is also useful when peritoneal lavage is contraindicated because of previous abdominal operations or pregnancy. There is no role for CT scan in the unstable patient.

Summary

Accurate identification of abdominal and thoracic injuries in blunt trauma is important in determining appropriate and timely therapy. In the past, evaluation and treatment has been based on clinical examination, peritoneal lavage and conventional radiography. We reviewed the records of ten patients sustaining blunt trauma during the past 12 months to determine the role of computed tomography (CT) in managing abdominal and thoracic injury.

All ten patients had CT of the abdomen; in addition 3 patients underwent CT of the chest and 2 other patients underwent CT of the head. Seven abdominal and two chest injuries were demonstrated by CT. Five patients were managed non-operatively and five patients underwent operation based on CT findings. Operation was delayed in one patient because of CT results. Peritoneal lavage was performed on two patients. Depending on the number of radiographic procedures obtained, patients spent between 30 and 155 minutes in radiology.

Based on our experience with 10 patients and a review of the literature, we feel that computed tomography has a role in the evaluation of stable patients with blunt abdominal and thoracic trauma. CT scanning yields additional information not available from peritoneal lavage. Further study will be necessary to determine the accuracy and efficacy of CT in the identification of intra-abdominal injuries.

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Uvulopalatopharyngoplasty: A Surgical Procedure for Obstructive Sleep Apnea and Social Snoring Problems

SLEEP apnea is a well documented clinicopathologic entity, not just in the obese, but also in apparently normal patients. It is also recognized that there is a subgroup of extremely loud snorers whose nighttime airway obstruction eventually progresses to intermittent total airway obstruction and sleep apnea.[1] It is this broad patient population that can potentially benefit from reduction of the redundant oropharyngeal tissue by means of a uvulopalatopharyngoplasty (UPP).

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History

The classic description of the "Pickwickian Syndrome", that is obesity, hypersomnolence, alveolar hypoventilation and cor pulmonale, was first described in 1956 by Burwell.[2] Ten year later Gastaut[3] demonstrated that intermittent airway obstruction caused no problems while awake, but during sleep caused abnormal sleep patterns which were responsible for the daytime hypersomnolence.

Several relatively recent developments have enabled further information to be obtained concerning snoring and sleep apnea: 1) Guilleminault s polysomnographic sleep lab studies[4] 2) fiberoptic examination of the nasopharnx, pharynx and hypopharynx to evaluate upper airway obstruction and 3) the improved resolution of the CAT scan.[5, 6]

The UPP concept was first introduced approximately two years ago as an experimental operation to avoid permanent tracheotomy in sleep apnea patients. The initial results of Fujita, Borowieki and Simmons[7, 8, 1] have helped determine indications and limitations for the technique. It has also revealed that non-positional loud snoring can be cured by UPP in the great majority of patients.

Etiology

The pharynx relies on sensory and muscular reflexes to maintain its patency during sleep.[7, 9] The exact reason why some people lose the ability to maintain a patent pharyngeal airway during sleep is uncertain. Sleep studies have revealed that velopharyngeal muscles and the tongue both have reduced tone during sleep,[5, 7] and a collapse of the pharyngeal airway coincides with obstructive apneic episodes.[10] Other well known etiologies of upper airway obstruction include nasal septal deformity, adenotonsillar hypertrophy, vocal cord paralysis, laryngeal anomalies and micrognathia.

Nasal septoplasty alone has not been an effective treatment for sleep apnea,[7] though nasal obstruction as a contributing factor to sleep apnea should not be ignored.

Diagnosis

The history is one of the most important features in making a diagnosis of sleep apnea. Extemely loud snoring is a common symptom and usually the first sign of sleep apnea. Often times it is the patient's bed partner who urges the patient to seek medical attention for snoring, because the patient is unaware of his snoring, is embarrassed by it, or does not know it can be corrected. Other major nighttime symptoms include restless sleep, insomnia and enuresis. Daytime symptoms commonly include morning headaches, hypersomnolence and personality disturbances.[9]

The routine physical exam may be unremarkable, but should be directed toward identifying sources of upper airway obstruction. The patient's weight, blood pressure, mandibular and maxillary bone structure and the nasal airway patency are all carefully noted. Redundancy of the mucosal folds of the posterior oropharynx and excess draping of the soft palate are searched for in both the sitting and supine positions. Indirect mirror exam is done to rule out an omega shaped epiglottis that can obstruct the laryngeal inlet.[7] Fiberoptic examination of the velopharynx should be performed to observe for collapse of the oropharyngeal air space on inspiration. If the initial evaluation suggests possible sleep apnea, a polysomnographic exam is performed to document the existence of apneic episodes, snoring and airway obstruction. Included in this evaluatin are a determination of sleep stages (EEG), eye movement (EOG) and muscle activity (EMG). Nasal/oral air movement is measured with thermistors. Chest wall respiratory effort, continuous EKG readings and ear oximetry are also monitored. Should the patient be suffering from significant oxygen desaturation, a cardiopulmonary consultation is obtained to rule out the possibility of cor pulmonale or cardiac arrythmias.

Management

If the history, physical exam and sleep apnea studies are all within normal limits, the patient should be followed in six months with a repeat examination.

Abnormal results of the polysomnographic recordings are classified as central, obstructive or mixed sleep apnea. Central apnea is due to failure of the brainstem to initiate the appropriate stimulus to the respiratory muscles. An obstructive apnea occurs when the upper airway is physically obstructed and collapses to a greater degree with ventilatory efforts. Mixed apnea is a combination of central and peripheral apnea which always begins as central, but is treated as obstructive apnea. Those patients with central sleep apnea should be further evaluated to rule out potential neurologic etiologies including brainstem tumors and infarction. The patient's clinical manifestation coupled with the diagnostic exam is used to determine the severity of the sleep apnea in the obstructive and mixed types.

A spectrum of sleep apnea is described for the clinical classification and prediction of UPP results: 1) Mild obstructive sleep apnea desaturates to 85% oxygen for greater than half of the sleep study and the major complaint is snoring. 2) Moderate sleep apnea has an oxygen desaturation between 85-50% and has a classic history for sleep apnea. 3) A severe sleep apnea has a desaturation below 50% O_2, cor pulmonale, the typical history of sleep apnea plus the risk of life threatening arrythmias.

Any physical anomaly causing airway obstruction should be removed or bypassed. Obesity and body habitus (short bull neck) may greatly contribute to the airway obstruction and hypoventilation syndrome, and should be initially treated with medical therapy. There are several reports of severe sleep apnea requiring urgent tracheotomy to prevent death from nocturnal hypoxia[7] or arrythmias. For this reason, severe sleep apnea patients should not be observed for months while attempting to shed massive excess weight, but rather demand a tracheotomy to bypass the airway obstruction while weight reduction is attempted.

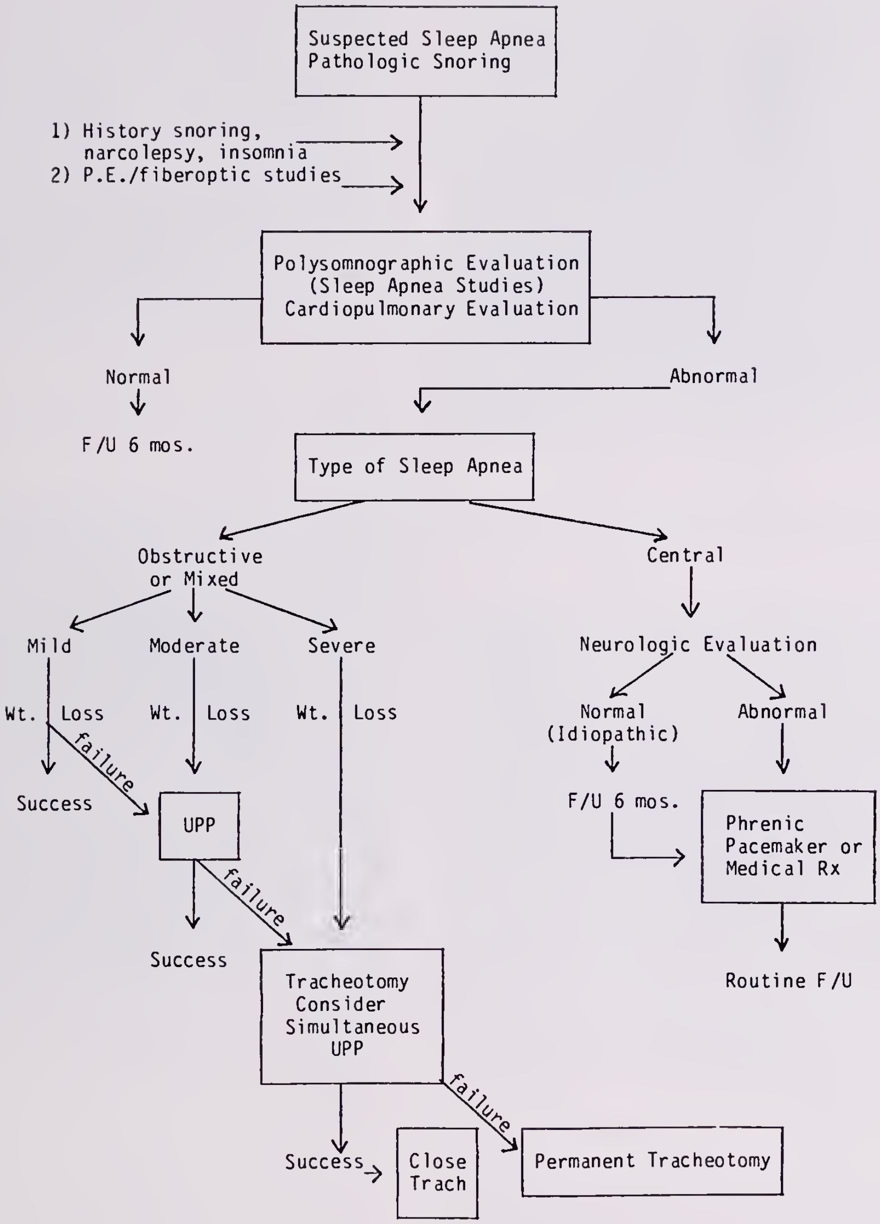
A management guide for the evaluation of patients with suspected sleep apnea and/or heroic snoring is outlined in Table I.

UPP Technique

A uvulopalatopharyngoplasty (UPP) is indicated when obstructive sleep apnea has failed medical management and significant socioeconomic difficulty is caused by daytime somnolence, or extremely loud snoring is disrupting the sleep of bedpartners.

Instrumentation and positioning of the patient are similar to that used in tonsillectomy. Using a general anesthetic a tonsillectomy is first performed, if the tonsils have not been previously removed. 2% Xylocaine with 1:100,000 Epinephrine is injected into the tonsillar fossa and soft palate for hemostasis. A mucosal incision, starting at the inferior anterior tonsillar pillar, is directed superiorly toward the apex of the uvula in a curvalinear fashion. The incision is deepened with sharp dissection to extend through the soft palate and this tissue is excised. The cephalad limit of the dissection is the thick musculature of the soft palate which can be both visualized and palpated. The posterior tonsillar pillar is grasped with Allis forceps and sufficient lateral traction placed on it to remove the posterior pharyngeal wall vertical

Table I. CASCADE DIAGRAM FOR SLEEP APNEA MANAGEMENT



creases. This excess pharyngeal tissue is excised. The remaining edge of the posterior pharyngeal mucosa is secured to the remnant of the anterior tonsillar pillar with interrupted 2-0 chromic sutues. The mucosal free edges of the soft palate are approximated in a like fashion. An attempt to recreate the uvula is optional since this is of esthetic value only. The technique of the UPP is illustrated in (Figures I a-d).

At the termination of the procedure, a significantly enlarged cross sectional area of the oropharynx is obtained and the posterior pharyngeal wall should be without mucosal folds. The muscular soft palate should still be able to oppose the posterior pharyngeal wall to allow velopharyngeal competence.

Any adjunctive airway improving procedure such as a septoplasty is performed after the UPP is completed, but during the same anesthesia. Postoperative care is essentially that of an adult tonsillectomy, i.e., hospitalization for 2-3 days or until the patient is tolerating oral fluids well.

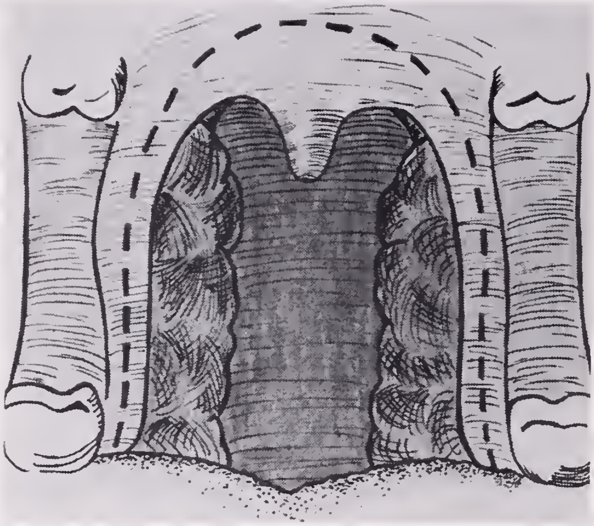


Figure I-a
Uvulopalatopharyngoplasty (UPP) Technique. Tissue to be resected in patient with tonsils outlined.

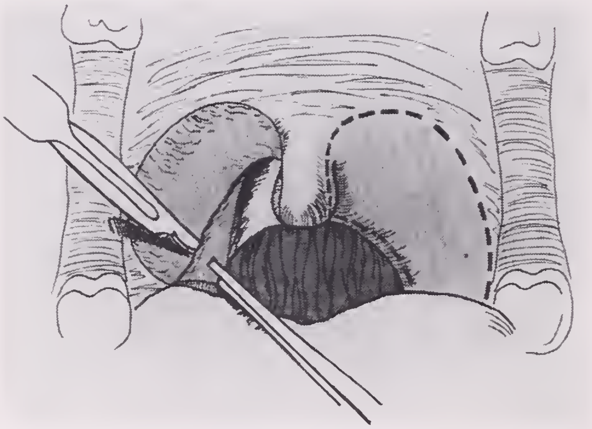


Figure I-b
Uvulopalatopharyngoplasty (UPP) Technique. Tonsillar fossa mucosa resected if tonsillectomy previously performed.

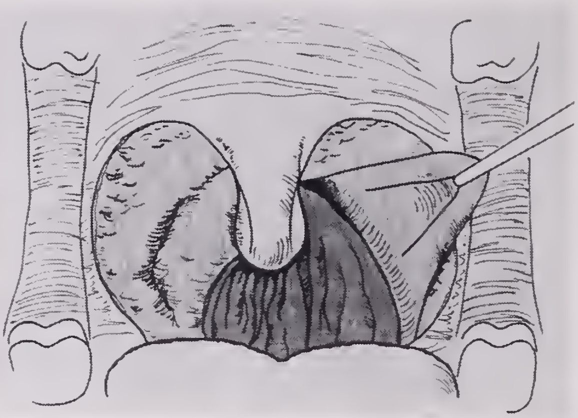


Figure I-c
Uvulopalatopharyngoplasty (UPP) Technique. Excessive posterior oropharyngeal wall mucosa excised.

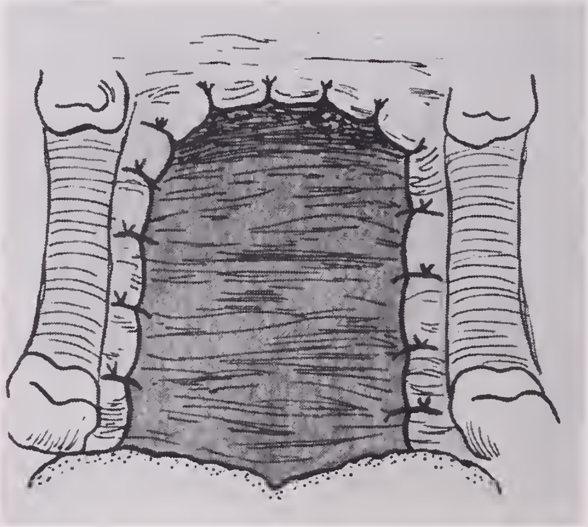


Figure I-d
Uvulopalatopharyngoplasty (UPP) Technique. Completed UPP.

Results

The results of the UPP were evaluated by three parameters: 1) degree of snoring, 2) subjective clinical improvement and 3) objective recordings of oxygen saturation. (Table II)

The UPP is an excellent means of curing heroic i.e., extremely loud, snoring. All of our patients and their bed partners have reported significantly decreased incidence and loudness of their snoring.

Subjective clinical improvement was reported in all patients. They have a decreased incidence of daytime somnolence, fatigue and restlessness at night.

The UPP procedure does not eliminate sleep apnea entirely. The oxygen saturation of patient #1 remains approximately at the preoperative levels, though he is subjectively improved and has no snoring. This patient has mixed sleep apnea and is also taking Theo-Dur. Patients #2 and #4 have improved oxygen saturation to mild sleep apnea level. Patient #3 failed to return for postoperative oximetry measurements. The tendency to improve with time has been reported by others;[7] therefore, repeat oximetry measurements will be obtained at six month intervals to note any further change. Patients #5 and #6 had the UPP done for heroic snoring only,

Table II. UPP Results

Patient #	Age & Sex	Weight	Sleep Apnea by Sleep Lab Diagnosis	Indications for UPP	Additional Surgery	"Patient's" Subjective Clinical Results	"Bedpartner" Snoring Status Evaluation	Trach
1	45 M	124 kg	moderate sleep apnea	obstructive mixed sleep apnea & snoring	none	improved	resolved	no
2	43 M	99 kg	moderate sleep apnea	obstructive sleep apnea & snoring	septoplasty	improved	resolved	no
3	59 M	99 kg	mild sleep apnea	obstructive sleep apnea & snoring	septoplasty	improved	resolved	no
4	34 F	100 kg	moderate sleep apnea	obstructive sleep apnea & snoring	none	improved	resolved	no
5	56 M	100 kg	no sleep apnea	snoring	septoplasty	improved	resolved	no
6	61 M	85 kg	no sleep apnea	snoring	septoplasty	improved	resolved	no

therefore pre- and postoperative O_2 measurements were not obtained.

We have had no complications to date with the UPP technique. Velopharyngeal insufficiency causing rhinolalia aperta and nasal regurgitation of fluids while eating are the two major potential complications of this procedure. We will continue to monitor for these as potential long term complications, though it is doubtful that they will manifest themselves in patients who are more than three months postoperative.[7]

Conclusion

Oropharyngeal airway obstruction should be recognized as a continuum ranging from loud snoring to severe sleep apnea with significant cardiopulmonary disease.

We can recommend the UPP procedure as an excellent solution for heroic snoring, i.e., snoring loud enough to wake a bed partner, be heard in adjoining rooms, or wake the patient with a choking sensation.

Patients with mild to moderate sleep apnea who have failed medical management may be able to avoid permanent tracheotomy and its disadvantages by increasing the oropharyngeal cross-sectional area with a UPP. Consideration should be given to perform a UPP in conjunction with tracheotomy on those patients with severe obstructive peripheral sleep apnea in the hope that with time the patient could be weaned from his trach tube.

Better standardization of polysomnographic recordings are required so that data may be interchangeable for statistical analysis between centers.

Long term follow-up, both subjectively and objectively, to monitor potential long term complications secondary to the UPP will be required for several years. Uvulopalatopharyngoplasty is transforming from an experimental operation into an established surgical procedure as an alternative to a permanent tracheotomy for those patients suffering mild to moderate obstructive sleep apnea syndrome and extremely loud or "heroic" snoring.

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Trends in Cesarean Section Rates in Nebraska, 1979 Through 1982

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IN 1978, 11.8% of all deliveries in Nebraska were by cesarean section.[1] For the same year, the percent of total cesarean sections in the United States was 15.2%.[2] Opinions that surfaced could be tabulated into three categories: 1) the United States percent was correct and Nebraska obstetrical practices were not keeping pace with reports advocating the effective use of cesarean delivery; 2) the percent in Nebraska was probably appropriate and there were more unnecessary cesarean sections performed nationally; 3) the percents for both Nebraska and the United States were too high. Performing a cesarean section was mentioned as a possible means of financial gain for both the physician and the hospital. The task force assembled by the National Institute of Child Health and Human Development, National Institutes of Health (NIH) at its Consensus Development Conference on Cesarean Childbirth on September 22-23, 1980[2] concluded from their studies that no financial gain was apparent. With the adoption of the "diagnosis related groups (DRG)" concept, financial gain from the performance of cesarean sections was again mentioned. A recent report from the Hastings Center, New York, concluded that a hospital in New Jersey realized a profit by encouraging physicians to increase the percent of cesarean sections.[3]

These judgments prompted a continuation of a prior study on the number of cesarean sections performed in Nebraska.[1] The results of the second study (1979 through 1982) revealed that Nebraska obstetrical practices "danced to a different drummer".

Study Design

Data for the total number of deliveries of live-born and stillborn infants over 20 weeks gestational age and total, primary and repeat cesarean sections were requested from the medical record administrator of each Nebraska hospital having a maternity service. All of the hospitals responded. The data were compared with appropriate birth and death certificates to insure completeness of collection. Cesarean sections were reported as percent. The denominator is the number of deliveries, not the number of live births.

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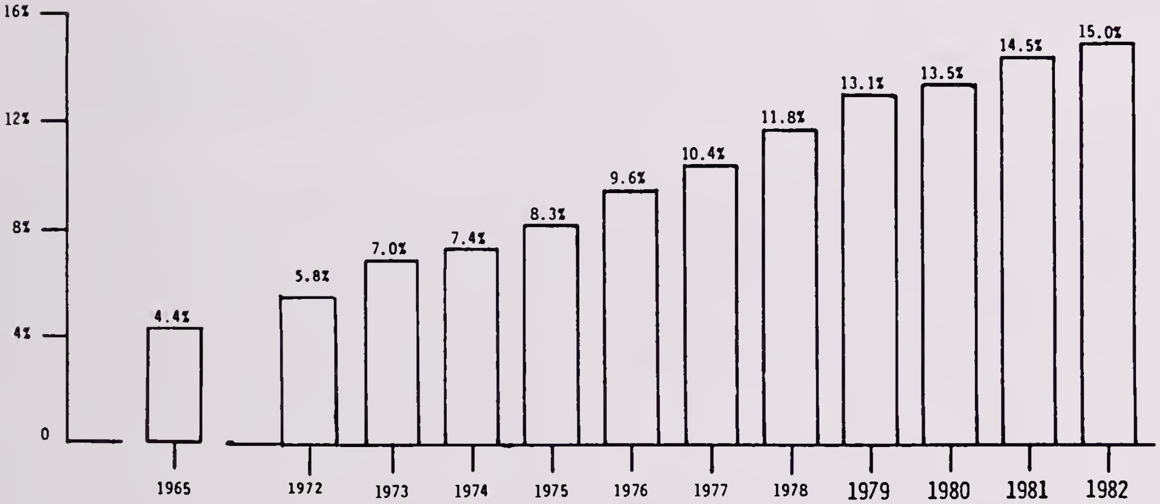
Results

The results of the survey, in terms of total deliveries, primary and repeat cesarean sections are shown in Table 1. There has been a continuous rise in the percent of total cesarean sections in Nebraska since 1965 (Figure 1). The percent of total cesarean sections in 1965 was 4.4%; in 1982 it was 15.0%.

TABLE 1. Total number of deliveries, Total, Primary and Repeat Cesarean Sections reported by Nebraska Hospitals, 1979 through 1982.

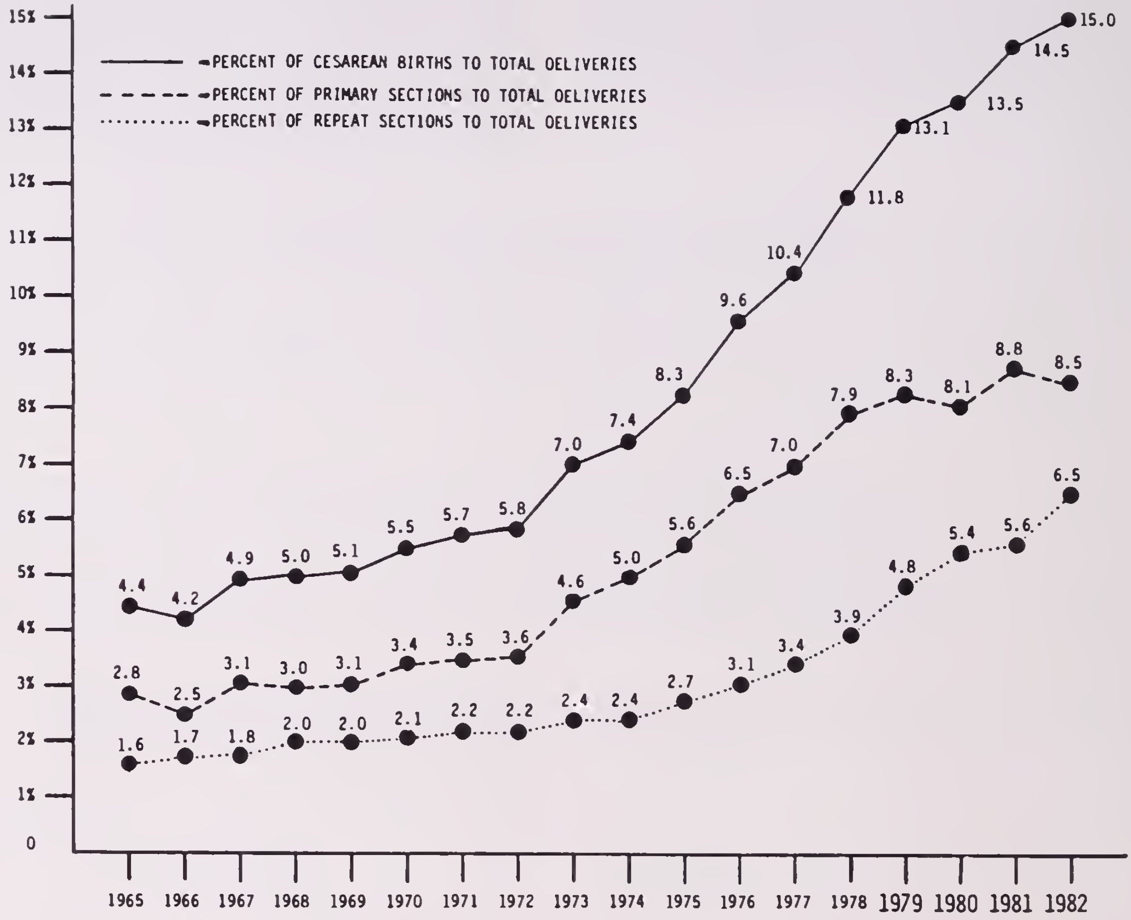
YEAR	1979	1980	1981	1982
TOTAL DELIVERIES	26,388	27,584	27,275	27,104
TOTAL CESAREAN SECTIONS	3,458	3,728	3,946	4,077
PRIMARY CESAREAN SECTIONS	2,204	2,243	2,413	2,315
REPEAT CESAREAN SECTIONS	1,254	1,485	1,533	1,762

FIGURE 1. Percent of Total Cesarean Sections reported by Nebraska Hospitals, 1965 - 1982.



The percents of total, primary and repeat cesarean sections from 1965 through 1982 are presented in Figure 2. The rate of increase in percent of cesarean sections to total deliveries has decelerated from 1979 to 1982 when compared with that from 1972 to 1979. The increase in the percent of repeat cesarean sections to total deliveries has continued to increase faster during 1979 to 1982 when compared with that from 1972 to 1979. During the first period the repeat cesarean sections accounted for one-third of the total percent of cesarean sections; in 1982, they accounted for 43%. The percent of primary cesarean sections has plateaued from 1979 to 1982. The increase in rate of cesarean sections in Nebraska is largely due to the continued rise in repeat cesarean sections.

FIGURE 2. Percent of Total, Primary and Repeat Cesarean Sections reported by Nebraska Hospitals, 1965 - 1982.



In 1982, ninety-seven hospitals in Nebraska provided obstetrical services. The incidence, by percent of cesarean sections for the hospital, ranged from 0 to 35.3% (Figure 3). Twelve hospitals reported none. One hospital reported 35.3%. Sixty-one hospitals had percents ranging from 9% to 19%. Twelve hospitals, which accounted for 8% of the deliveries and 11.7% of the cesarean sections, reported cesarean section percents of 20% or above. In 1978 eight hospitals with a cesarean section percent of 20% or above accounted for 5.4% of the deliveries and 10% of the cesarean sections.

During the 1960's the concept of obstetrical regionalization was introduced in Nebraska to provide quality services for either the expectant mother, her fetus or the sick neonate. Hospitals with a large number of deliveries were assumed to have the resources and expertise to become secondary and tertiary centers. In Nebraska neonatal intensive care centers were the first to be designated, then obstetrical intensive care followed. Both offered consultation to the community or primary level hospital. In addition a number of primary care physicians availed themselves of additional obstetrical and pediatric postgraduate studies, thus increasing their ability to provide additional levels of obstetrical and neonatal intensive care. In a previous publication an attempt was made to show the relationship between the size of the maternity service and cesarean section percents.[1] Hospitals were divided into five groups according to the number of deliveries in 1978. The respective groupings were: Category A - 1,000 plus deliveries; Category B - 500 to 999 deliveries; Category C - 300 to 499 deliveries; Category D - 100 to 299 deliveries; and Category E - 1 to 99 deliveries. Approximately 50% of the 97 hospitals with obstetrical services have less than 100 deliveries per year. The data for each category for 1978 and 1982 are presented in Table 2.

In 1982 hospitals in all categories reported increases in total percents of cesarean sections. The absolute increase in hospitals having 500 plus deliveries (Categories A and B) and those having fewer than 100 deliveries a year (Category E) was the result of repeat operative procedures. Hospitals in Category C and D (100 to 499 deliveries a year) reported increases in both primary and repeat cesarean sections. Further evidence of change in cesarean section rates is shown by plotting the hospitals and their cesarean section percents for 1978 and 1982, Figures 3, 4 and 5. Changes in distribution of and their percents of cesarean sections indicate that more hospitals are reporting the use of cesarean sections. In 1982, twenty-one (21) hospitals reported no repeat cesarean sections, whereas in 1978, thirty-three (33) hospitals reported no repeat cesarean sections.

Discussion

The percents of total cesarean sections for Nebraska are 13.1%, 13.5%, 14.5% and 15.0% for 1979, 1980, 1981 and 1982 respectively. For the corresponding years, the percents of total cesarean sections for the United States are 17.2%, 17.2%, and 19.3%.[4] National data are not available for 1982. The absolute difference in percents of total, primary and repeat cesarean sections for the two periods, 1972 to 1978 and 1979 to 1982 are presented in Tables 3 and 4. The increase in the percent of total sections during the later period is the result of repeat cesarean sections.

Obstetrical departments in the past prided themselves on a low cesarean rate. With the advent of appropriate anesthesia and surgical teams, available blood and antibiotics, a cesarean birth became a relatively safe procedure for the mother. Due to legal and social pressures, the emergence of the specialties of neonatology and maternal-fetal medicine, obstetrics has become a specialty of two patients - the mother and the fetus. Numerous articles in the medical literature have advocated an increase in the number of cesarean sections to improve perinatal outcome.[2, 5] Technical advances in the surgical procedure for a cesarean section have made it feasible for a mother to

TABLE 2. Nebraska Hospitals Categorized by Number of Deliveries, Percent of Total, Primary and Repeat Cesarean Sections for 1978 and 1982.

			TOTAL CESAREAN SECTIONS		PRIMARY CESAREAN SECTIONS		REPEAT CESAREAN SECTIONS	
			1978	1982	1978	1982	1978	1982
STATE			11.8%	15.0%	7.9%	8.5%	3.9%	6.5%
HOSPITAL CATEGORY	NUMBER OF DELIVERIES	NUMBER OF HOSPITALS						
A	1,000 +	6	13.5%	15.6%	9.3%	8.7%	4.2%	6.9%
B	500-999	11	12.9%	15.7%	8.4%	8.8%	4.5%	6.9%
C	300-499	4	9.3%	12.5%	6.6%	8.4%	2.7%	4.1%
D	100-299	31	10.4%	15.1%	6.7%	8.6%	3.7%	6.5%
E	1-99	45	7.1%	11.0%	5.6%	6.2%	1.5%	4.8%

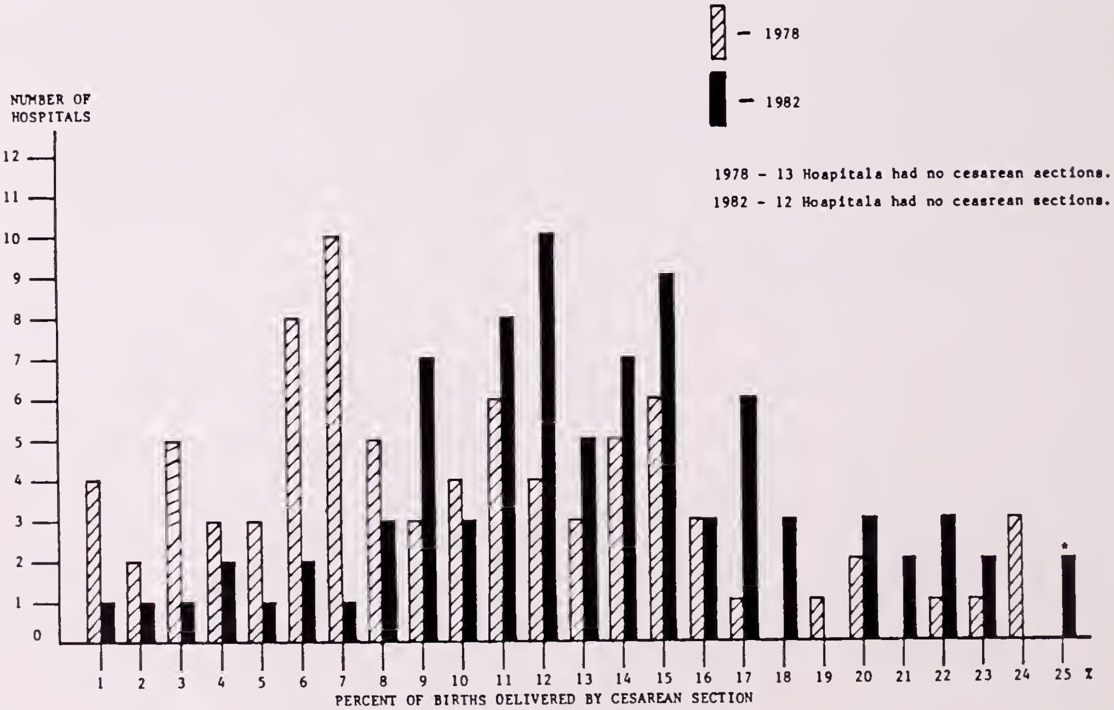
TABLE 3. The absolute difference of percents of Total, Primary and Repeat Cesarean Sections, Nebraska, 1978 and 1972.

	TOTAL CESAREAN SECTIONS	PRIMARY CESAREAN SECTIONS	REPEAT CESAREAN SECTIONS
1978	11.8%	7.9%	3.9%
1972	5.8%	3.6%	2.2%
Absolute Difference	6%	4.3%	1.7%

TABLE 4. The absolute difference of percents of Total, Primary and Repeat Cesarean Sections, Nebraska, 1982 and 1979.

	TOTAL CESAREAN SECTIONS	PRIMARY CESAREAN SECTIONS	REPEAT CESAREAN SECTIONS
1982	15.0%	8.5%	6.5%
1979	13.1%	8.3%	4.8%
Absolute Difference	1.9%	0.2%	1.7%

FIGURE 3
Incidence (percent) of Total Cesarean Sections in Nebraska Hospitals, 1978 and 1982.

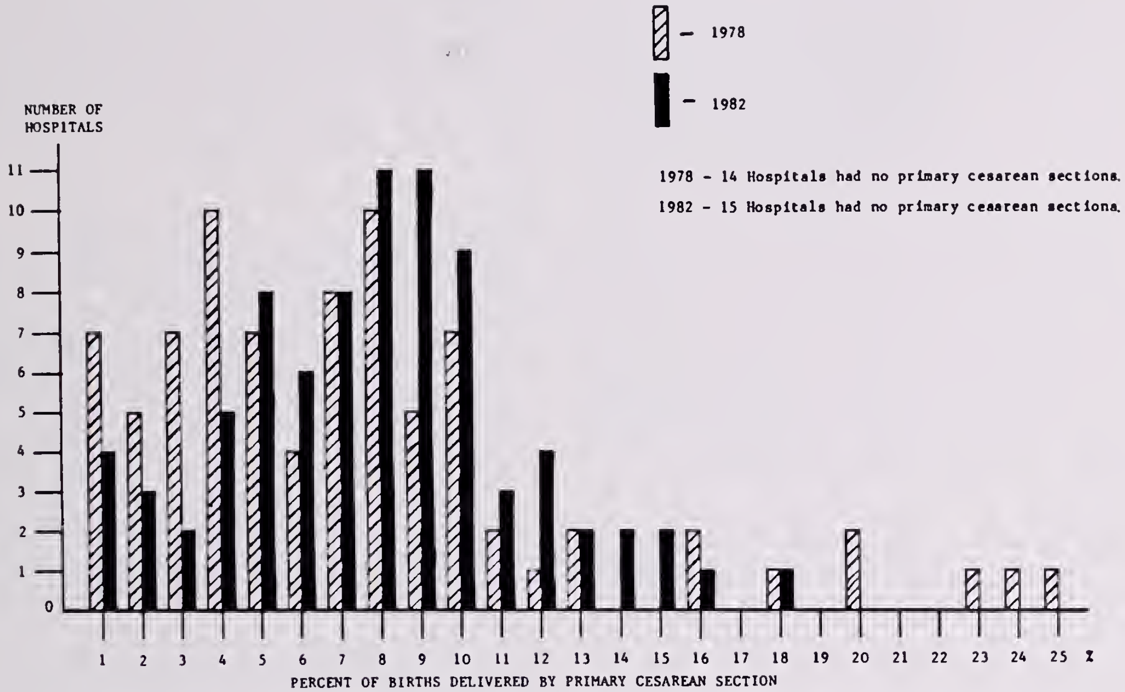


1978 – 13 Hospitals had no cesarean sections.

1982 – 12 Hospitals had no cesarean sections.

*Includes one hospital at 33.3% and 35%

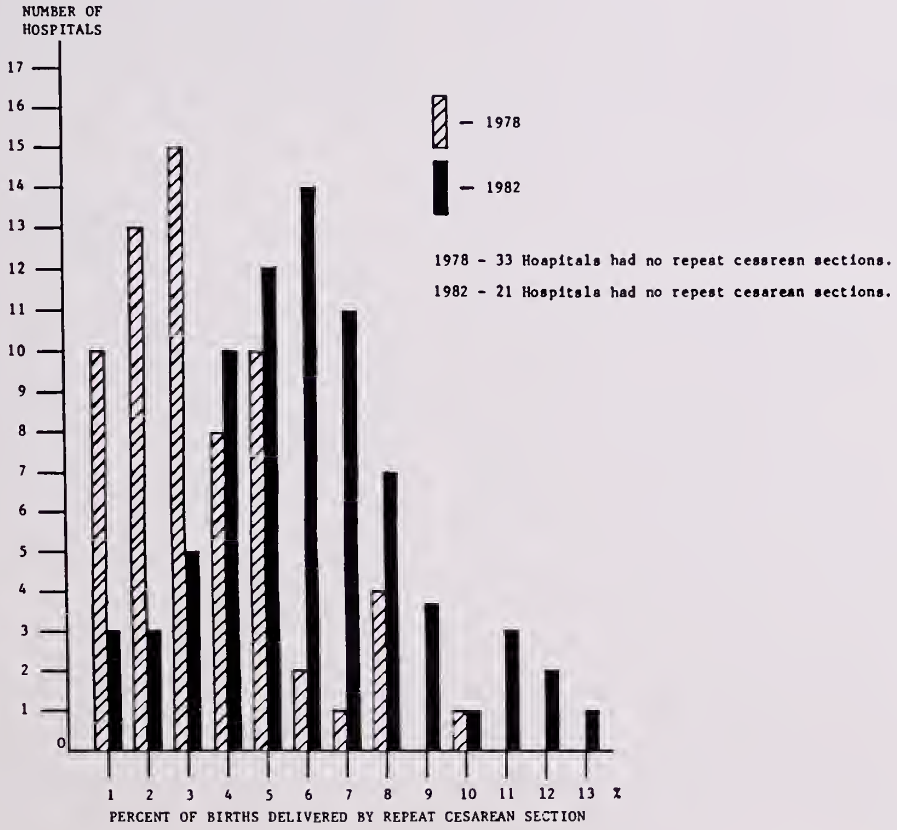
FIGURE 4. Incidence (percent) of Primary Cesarean Sections in Nebraska Hospitals, 1978 and 1982.



1978 - 14 Hospitals had no primary cesarean sections.

1982 - 15 Hospitals had no primary cesarean sections.

FIGURE 5. Incidence (percent) of Repeat Cesarean Sections in Nebraska Hospitals, 1978 and 1982.



1978 - 33 Hospitals had no repeat cesarean sections.

1982 - 21 Hospitals had no repeat cesarean sections.

experience a subsequent vaginal delivery.[6]

Nebraska physicians utilized the expanded indications for cesarean sections. The percent of primary cesarean sections increased precipitously from 1972 to 1979. With the "stabilization" of the number of pregnancies and obstetrical risk population, the increased percents of total cesarean sections from 1979 through 1982 has been due to repeat cesarean sections. This may be a reflection of limited obstetrical and hospital resources for a vaginal delivery after a previous cesarean section, or the refusal of expectant mothers with a previous cesarean section to be transferred to obstetrical centers where twenty-four hour resources are available, or expectant mothers wanting a repeat cesarean section.

Summary

The percent of cesarean sections performed in Nebraska continues to be less than the national percent. In Nebraska an increase in the percents of cesarean sections was noted from 1979 through 1982, but the increase was not as precipitous as that reported from 1972 through 1978. During the earlier period the increase was the result of primary cesarean sections, while during the later period the increase was the result of repeat cesarean sections. More hospitals reported cesarean sections to effect a delivery.

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Familial and Environmental Factors Involved in Inflammatory Bowel Disease in Rural Nebraska

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IT has been 52 years since Crohn first presented the description of regional enteritis to the annual meeting of the American Medical Association in New Orleans, Louisiana.[1] Since that time, the etiology of inflammatory bowel disease still remains unknown. Infectious, immunological, genetic, and environmental causes have been explored.[2] While no single cause has been isolated, the genetic factor has received considerable attention. There is a much higher number of affected relatives than would occur by chance.

It has been called to our attention that there were an increasing number of cases being seen in two relatively small counties in the state of Nebraska. There were also three patients in which there was strong family history associated with their disease. Two or more people in the same family had inflammatory bowel disease. For this reason, we decided to look into the environmental and familial factors involved with the patients in these two counties.

Materials and Methods

We began by reviewing all of the records associated with inflammatory bowel disease in the local hospitals. The doctors' office and clinic records were pulled and the names of those patients were obtained. The records from the local ostomy club were also reviewed for possible cases for our study. Thirty-one cases were reviewed, 6 of which were diagnosed in 1983. A questionnaire was devised, following review of the records, and sent to each patient. This questionnaire was an attempt to arrive at various racial, ethnic, geographical, occupational, religious, and genetic factors which might be involved with the etiology of inflammatory bowel disease (IBD). Only those records of patients from Merrick and Hamilton counties were included in this study and the records of those patients from 1977 until the present were reviewed.

Results

All patients in our study were Caucasians, the majority of which were of German descent. The birthplace, except for one, was all in Nebraska. The age range was from 15 to 75 years at the time of our study. The questionnaires were sent out to 31 patients, 27 of whom returned the questionnaires and were quite willing to participate in our study. There was 1 patient who was deceased, 2 patients who refused to participate, and a fourth patient who felt that she did not have any of the inflammatory bowel diseases in question. There were 10 males and 17 females involved. All but 3 were married. There were 24 Protestants and 3 Catholics. Fourteen of the patients had education beyond the high school level, 13 had high school or below. The diagnosis of chronic ulcerative colitis was made in 15, and Crohn's disease in 11. One patient had been found to have a toxic megacolon in the past and then was found to have regional enteritis or Crohn's disease on her most recent surgical exploration.

Questons regarding environmental toxins did not prove to be statistically significant. There were 10 patients involved in the study who gave a positive history for allergies, either drugs, foods, or pollens. We found 8 people to admit to smoking cigarettes. There were 3 patients with chronic ulcerative colitis and 3 with Crohn's disease who admitted to a positive diagnosis either in themselves, or their family, of rheumatoid arthritis. We did not find any patients who specifically had ankylosing spondylitis. Eleven of the 27 patients had some type of surgical procedure performed for their disease.

Most interesting to us were the 3 patients who gave a positive family history. One family involved 2 females, ages 15 and 22, both sisters of German descent, one in high school, the other a graduate nurse. There were no other members of the family involved with inflammatory bowel disease and the remainder of their history was essentially noncontributory with the exception of the oldest who also had a history of Hodgkins' disease. Both were afflicted with ulcerative colitis and both have had total proctocolectomies.

The second patient was 44 years of age and of German descent. She gave a history of toxic megacolon in 1970 and underwent a total proctocolectomy. She was recently seen with acute and chronic small bowel obstruction secondary to a current diagnosis of Crohn's disease. The patient's maternal family history was quite significant. Her grandfather was afflicted with a bowel disease which was never diagnosed. However her mother had a history of ulcerative colitis first diagnosed in 1945. A sister was diagnosed as having ulcerative colitis. The patient had an aunt with Crohn's disease and a nephew with a history of granulomatous colitis. There were several other members of the family having gastrointestinal problems which were never diagnosed. The remainder of the patient's history was essentially noncontributory as far as environmental factors were concerned.

The third and final patient was a 51 year old female of mixed German, Swedish and Danish descent, with a history of Crohn's disease. She had a strong family history which included one maternal aunt with Crohn's disease, and one paternal aunt with Crohn's disease and/or sprue. The patient came from a family of two sisters and one brother. The brother was diagnosed as having Crohn's disease. However, both of her sisters were unaffected. The patient's father was also diagnosed as having Crohn's disease and is now living in a neighboring county but originally had come from Hamilton County. This patient has had no previous surgery relating to her disease, although was still quite symptomatic, taking Azulfidine daily and having several stools daily.

The counties of Hamilton and Merrick have a total population approximating 18,000. Converting our prevalence figures of 27 would give us an overall prevalence rate of approximately 144 per 100,000. The incidence of 6 per 18,000 would convert to 33 per 100,000. This is quite obviously much higher than the general incidence we have found in the literature.

Discussion

The incidence of regional enteritis in the general U.S. population of Baltimore in 1966 was estimated by Mendeloff et al to be 1.35 per 100,000[3] and in Cardiff by Mayberry et al to be 5 per 100,000[4]. The prevalence is approximately 40-100 per 100,000.[2] Multiple occurrences within families, of a disease of low incidence, is of obvious significance. It has been suggested that the chance occurrence of familial inflammatory bowel disease is perhaps 1 in 1,000,000 for ulcerative colitis and 1 in 25,000,000 for regional enteritis.[5]

Dassel studied approximately 1,200 new cases of inflammatory bowel disease from 1960 to 1977.[6] Within this group, there was a familial incidence of approximatley 2.5%. These patients were Caucasian, and of non-Jewish descent. It should be noted that the Jewish population has approximately a 5 times greater incidence of familial inflammatory bowel disease than the remainder of the general population.[7] Ulcerative colitis is more likely to occur in the family of probands with ulcerative colitis, and the same relationship holds for Crohn's disease, but intermingling has been noted by various authors and is estimated at about 25% of familial occurrences. The finding of the disease in spouses, would have lent strong support for an infective etiology, is exceptional.

Singer, et al, described a familial occurrence rate of 17.5% with 113 of 646 patients with IBD.[8] Other recent studies have emphasized the occurrence of IBD in multiple family members and the peculiar predilection for familial aggregation of patients with ankylosing spondylitis in Crohn's disease.[9,10,6] There has been no pattern which has emerged to suggest a specific genetic link. The work of Singer, et al, included observations of a large number of Jewish patients with IBD as well as the association of Crohn's disease with ankylosing spondylitis.[8] They noted from the evidence that the genetic mechanism likely does not involve either a single dominant or a single recessive gene with incomplete penetrance. Kirsner noted that familial occurrences more often involve first degree relatives (parent, child or siblings) rather than second or third degree relatives (aunts, uncles, nieces and nephews).[11] Lewkonia & McConnell felt that the association within families may be due to a common environmental etiology but more probably is due to a shared genetic background.[12] They also noted that studies relating to environmental or hereditary factors in IBD yielded confusing results; there are relatively few examples of involvement of spouses, adopted children and individuals in a similar environment. They also reviewed data concerning the linkage of ABO blood groups and HLA antigens with the exception of spondylitis and Crohn's disease. They noted that familial IBD is much more common than would be expected on the basis of random chance. However, the magnitude and frequency of occurrence has remained unclear.

There is no evidence that place of residence, parental education, social economic status, familial rank or familial occurrence of other forms of gastrointestinal disease contribute to an increased risk of IBD.

Conclusion

The incidence and prevalence of inflammatory bowel disease studied in two Nebraska counties was found to be much higher than that in the literature reviewed. Our study also revealed an 11% positive family history which is likewise higher than that noted in the literature. Like most reports before us, we could draw no other definite conclusions from this small study.

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SPECIAL ARTICLE

The Best That Medical Science Has to Offer

1984 Medicine Honors Convocation Student Address

May 12, 1984

Joslyn Art Museum

Omaha, Nebraska

EDWARD P. RAINES, J.D., M.D.*

ON Monday, March 30, 1981, the 40th President of the United States, Ronald Reagan, was shot as he walked out of the Washington Hilton Hotel in Washington, D.C. The public learned later that the wound he sustained was quite a severe one and that his doctors and their application of modern medical techniques were literally able to save his life.

It is interesting, and instructive, that almost exactly one hundred years previously, the 20th President of the United States, James A. Garfield, was also shot in Washington, D.C. While President Garfield, like President Reagan, received the best care that medical science could offer at the time, the state of the medical art in 1881 was distinctly different than we know it today.

James Garfield was elected President in 1880 and, like Reagan, was a Republican and a healthy, vigorous man.[1] On the morning of July 2, 1881, he was shot in the back by Charles Guiteau in the Washington, D.C. train station. The ensuing scene was described as one of great confusion and terror. The assassin was apprehended and a prominent local surgeon, Dr. D.W. Bliss, was immediately summoned to the aid of the President.[2] Dr. Bliss found President Garfield still conscious when he arrived — his face described as a ghastly white, respirations slow and complaining of numbness and tingling in his legs and feet. The bullet's entry would was found to be approximately 4 inches to the right of the eleventh thoracic spine and in accordance with accepted surgical practice of the day, the doctor immediately began to explore the President's wound with a Nelatin probe — tipped with a rough porcelain end to snag and remove foreign bodies.[2] When he was unable to locate the bullet with the Nelatin probe, he tried a long flexible silver probe and finally inserted his left little finger — all unsuccessfully and without anesthesia. No effort had been made to sterilize his instruments or his finger, inasmuch as the concept of antisepsis was merely beginning to gain attention in 1881. In fact, in 1885, four years later, Dr. William Halsted, a giant in American medical history, was forced to perform surgery in a tent outside Bellevue Hospital as the sterile techniques he promoted were accepted by few.[2]

Unable to locate the bullet and, unknowingly, having thoroughly contaminated the wound, President Garfield was placed in a horse drawn ambulance and taken, not to an emergency department or intensive care unit, but rather back to the White House for his medical care. Specialists from New York and Philadelphia were hurried to Washington but despite repeated probings, they too were unable to locate the bullet. Without the aid of x-rays, the bullet's location remained a mystery. Alexander Graham Bell, however, known as inventor of the telephone, offered his services inasmuch as he had noticed early in his experiments that a metallic object located between two electric coils caused a faint buzzing sound to be heard.[2] By placing two such coils on the back of President Garfield, he thought he heard a faint buzzing on the right side of Garfield's abdomen, opposite the site of the bullet's entry. The attending surgeons

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concluded that the bullet was lodged in the President's liver beyond the reach of contemporary surgery and that nothing further could be done.

President Garfield endured a steadily declining course over the next 80 days and underwent twice daily probings during that time. His chief source of nourishment was milk from a cow tethered on the White House lawn and enemas consisting of raw eggs, beef extract and whiskey. During the course of his illness Garfield went from a fit and robust 210 lbs. to an emaciated 135 and was described as appearing "pitiable in the last degree."[3] Infection spread throughout his body and on Sept. 17, 1881, President Garfield was relieved of his suffering and died. His doctors described him as a "wonderfully patient sufferer" — high praise considering that during his 80 day ordeal, he had received no I.V. fluids, no hyperalimentation, no x-rays, no blood transfusions, no antibiotics and no definitive surgery.[3]

On autopsy it was found that the doctors had been entirely inaccurate in their estimation of the bullet's location and the nature of President Garfield's wound. Instead of traveling on a straight course through his abdomen to the liver, the bullet had instead been deflected by the 11th rib, passed in front of the spinal cord, fracturing the first lumbar vertebral body and was safely encysted in the back musculature immediately to the left of the spine. A large abscess cavity was found where the doctors had so frequently and vigorously probed in the back. The immediate cause of death was determined to have been due to hemorrhage from a traumatic aneurysm of the splenic artery. A clot had safely organized around the bulging artery but had been softened by the severe bacteremia initiated by the persistent probing leading to it's rupture and the ultimate death of President Garfield.

When charges were brought against Charles Guiteau for the assassination of President Garfield, the defendant was emphatic in denying responsibility for Garfield's death, assuring the Court that it was the doctors who had killed him, suggesting that he had merely shot at the President.[4] Obviously, creative defenses are nothing new to the 20th Century. However, in retrospect, the defendant was technically correct inasmuch as no major arteries or veins had been directly struck by the bullet nor had any major organs been seriously damaged. If President Garfield had simply been managed with minimal supportive care, it is quite conceivable that he could have survived his injury. The best that medical science had to offer in 1881 had a substantially more deliterious effect than a beneficial one in the assassination of President Garfield. Fortunately, the state of the medical art had progressed dramatically when Ronald Reagan required the best that medical science could offer on March 30, 1981.

On that day at approximately 2:30 p.m. President Reagan was walking out of the Washington Hilton Hotel when several shots were fired. One of several Secret Service agents instinctively pushed the President into his waiting limousine. When Reagan was asked if he was alright, he said the Secret Service agent had landed on top of him and hurt his ribs. 10 to 15 seconds later, however, he started coughing up a significant amount of blood and the seriousness of his injury was obvious.[5] The George Washington University Emergency Room was called by mobile telephone and told that the Presidential motorcade was enroute. The Emergency Room staff had no idea who was hurt or the nature of the injuries, but when the President's motorcade arrived, the President of the United States got out of the limousine and complained that he could not catch his breath. His knees buckled and he was helped into one of the E.R. examining rooms. His shortness of breath, chest pain and pale skin appeared initially to be due to a heart attack until blood was seen on his mouth and hands. Following the usual protocol, an E.R. nurse attempted to obtain the President's blood pressure but it was already too low to even get a reading due to blood loss. An I.V. line was immediately placed and the President's cloths were cut off. When an E.R. doctor listened to Reagan's heart and lungs, he noted significantly reduced breath sounds on the left suggesting that his lung had collapsed. The entry site of the bullet was found just below the left armpit. No exit wound could be found. Within minutes, using sterile techniques, a chest tube was place in the President's left chest cavity to remove fluid and re-expand his lung. 1300 c.c., or roughly one quarter of the President's blood volume, gushed out of the chest tube and a significant amount of blood continued to drain from his chest.[5] Fortunately, the I.V. fluids restored much of the lost blood volume and the President's blood pressure improved. An x-ray machine was brought directly into the trauma room and within minutes, the bullet was localized in the left lung just behind the heart. Unfortunately, bleeding from his chest continued at a significant rate and it was soon obvious that President Reagan would require emergency surgery to repair the site of hemorrhage. After being in the hospital for only 35 minutes, he was taken to the operating room for a lifesaving procedure. As he was lifted from the stretcher to the operating table, President Reagan was composed enough to say, "Please tell me you're all Republicans." In fact, his surgeon was a liberal democrat but assured the President that, "Today we're all Republicans, Mr. President."[5]

When Reagan's chest was opened, over 500 c.c. of clotted blood was removed bringing his total loss to over 3000 c.c., approximately one-half of his total blood volume. Without the I.V. lifeline he almost surely would have severely damaged vital organs due to a lack of circulating blood volume.

At operation the bullet was not easy to find; after feeling for the bullet for some time by hand, an intra-operative x-ray was required to finally locate the .22 caliber slug that had been flattened to the size of a dime. President Reagan's post-operative course was not uneventful; he experienced a troublesome persistently recurrent fever and an episode of re-bleeding which nearly required a second operation. However, with the benefit of highly effective antibiotics and expert care, he has fully recovered to be a remarkably vigorous septuagenarian.

In 1981, unlike 1881, the best that medical science had to offer saved the life of a man whose injury would have otherwise been almost certainly fatal. President Reagan, unlike President Garfield, was kept alive by the use of antibiotics, fluids, electrolyte and blood replacement, an ultra-modern laboratory, modern anesthesia and ventilatory support, sophisticated surgical techniques, bronchoscopy, angiography, C.A.T. scans and nuclear scans — all beyond even the wildest imagination in 1881.

The changes which occurred in medicine over those 100 years are patently obvious and the methods of medical care performed by a physician have dramatically improved. Those changes did not evolve at a steady state, however, but have progressed at an ever more rapid pace. In our lifetime as medical and surgical practitioners we will come to accept change and the ever increasing pressure to keep up with that change as a most formidable challenge. As physicians of the future, we will face the challenge more than any graduating class that has preceded us. Crushing kidney, bladder and even gallbladder stones with ultrasonic energy rather than surgery, removing arterial atherosclerotic placques with lasers placed inside the arteries, treating selected diseases in the weightlessness of space, transporting cancer chemotherapeutic agents and other drugs to specific sites of action by monoclonal antibodies, diagnosing metabolic abnormalities in living tissues with nuclear magnetic resonance, using 3-D C.A.T. scans to examine active organ function and tumor configuration, routine transplantation of human and artificial organs, selective modification of specific chromosomes and production of human hormones by bacteria through genetic engineering, and even the cure of cancer will all be the accepted state of the medical art in the very near future. The magnitude of change which took place over the past 100 years will likely occur in one-quarter that time or less in our careers.

In addition, socio-economic and governmental factors affecting the delivery of health care will change almost as dramatically. We and our future professional colleagues will face Professional Review Organizations, Preferred Provider Organizations, Diagnosis Related Groups, the physician glut and a miriade of other regulatory modifications unlike those who practiced medicine before us. While we are honored, privileged and undoubtedly relieved to pass this milestone in our medical careers, the more formidable challenge most definitely lies ahead. Although the challenge may at first blush appear almost overwhelming, the benefit that we as physicians will be able to provide to our patients will also be greater than ever and the gratification of mastering such a sophisticated art will be correspondingly significant.

In closing I would like to share with you an allegory — of two men riding across the plains of the Midwest in the early 1800's. As they approached a nearly dry river bed, anxious to water themselves and their horses after a long day's ride, a strong, powerful and authoritative voice rang out from the sky and said, "Get off your horses." The men were startled and frightened by the suddenness and power of the voice and immediately dismounted. The voice rang out again and said, "You have obeyed well. Now go to the river bed and fill your pockets and saddlebags with pebbles and stones." Again the men were frightened by the authority of the voice and quickly filled their pockets and the saddlebags of their already weary horses with the worthless pebbles and stones. The voice was heard a third time and said, "You have obeyed well. Remount your horses and ride as long as light permits and in the morning when you wake you will be both happy and sad." Again the men obeyed and after a fitfull night of sleep, woke up and began to empty their pockets and saddlebags of the worthless and burdensome load. When they did they found that the rocks had turned to precious gems — emeralds, rubies and diamonds and that in fact they were both happy and sad. Happy that they had obeyed the faceless voice but sad that they hadn't taken more.

Over the course of our 4 years of medical school, we can all recall occasions when we were asked to fill the pockets of our minds with seemingly worthless bits of information and reluctantly complied only to find later that the information was vital to the care of a particular patient. As we end our career in medical school, we are happy that we put in the endless hours of study to become doctors. Yet, as we face the responsibility of ourselves caring for patients, we are sad that we didn't learn more. We are also happy to begin a new phase of the long journey of becoming physicians, but are sad to leave the colleagues who we grew with over the past 4 years and came to admire, respect and even love. With this passage to a new challenge, the graduates of the U.N.M.C. Class of 1984 are to be congratulated, and the families and friends who supported us in many ways to be gratiously thanked. We can all certainly be proud that we will be an integral part of the best that medical science has to offer for many years to come.

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FRACTURE OF THE MONTH

Fibular Head Dislocation - Another Differential in the Diagnosis of Knee Injury

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A 30 year old man presented with a complaint of right knee pain 6 hours after a dirt-biking accident. The patient described an injury to the knee as the bike came forward out from under him on a steep embankment and then fell back against his leg.

Initial physical exam of the right knee showed no effusions, ligament instabilities, or patellar dislocation or tenderness. Any movement of the knee caused extreme pain, and the patient had both medial and lateral joint-line tenderness. He held the knee at about 30° of flexion. He complained of tenderness located over the prominent right fibular head. When compared with the normal left side, clinically and radiographically, the right fibular head was noted to be displaced anteriorly and inferiorly (Fig. 1).

Discussion

The proximal tibiofibular joint is a diathrodial articulation with potential of dislocating anterolaterally, posteromedially, or superiorly. The anterolateral dislocation is by far the most common in adults and results from forceful inversion and plantarflexion of the foot with the knee flexed and the hamstrings relaxed. Posteromedial dislocation results from direct trauma as, for example, a horseback rider brushing the side of his leg against a gatepost or tree. Superior subluxation or dislocation is a childhood malady associated with congenital ligamentous laxity, or shortening of the tibia.[1]

Subluxation and instability of the proximal fibula should especially be considered in the differential of meniscal tears during adolescence and childhood. The patient usually gives a history that the knee gives way, locks, clicks, or limits participation in sports. The pain can be diffuse and readily mimics meniscal tear superficially. However, the quadriceps does not atrophy, nor does the knee swell, except for the prominence and palpable instability of the fibula. This is best evaluated with the patient's knee flexed to relax the hamstrings. With the

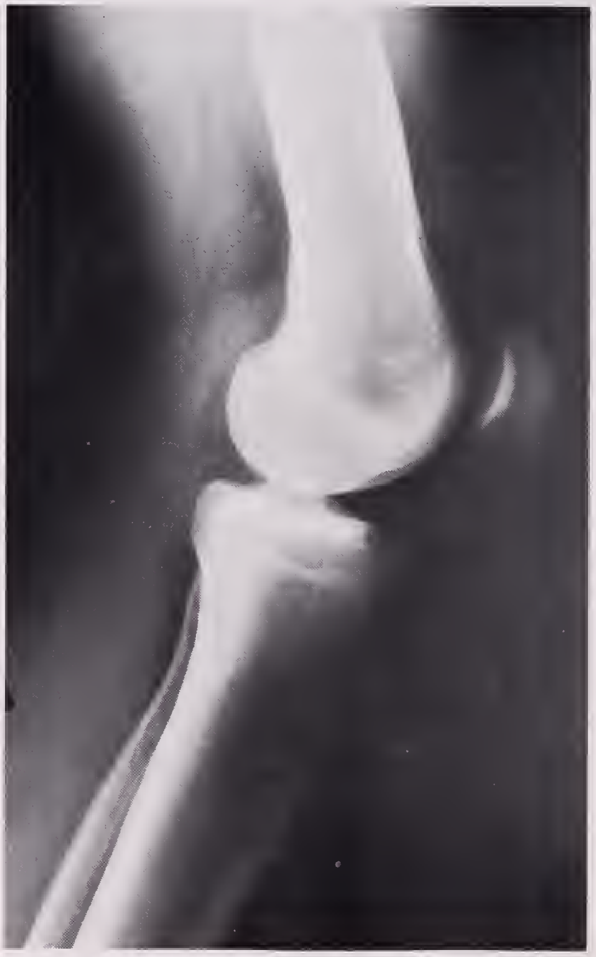

FIGURE 1: Lateral roentgenogram at the time of initial exam demonstrates anterior and distal displacement of the fibula.

knee in this position, the unstable fibula head can be readily moved anteriorly and laterally with a click. Despite these characteristic physical findings, 30% - 40% of proximal fibula head dislocations go unrecognized, at least initially.[2,3] It is important to keep in mind this problem of fibula instability and particularly to avoid erroneous meniscectomy.

Management

Reduction, in this case, was done immediately using intravenous Valium sedation. While the surgeon applied posteriorly directed pressure on the fibular head, the assistant rapidly dorsiflexed and everted the ankle. A distinct pop was heard and felt. The fibular head was instantly less tender and the knee could then be extended. X-rays demonstrated satisfactory reduction after this maneuver Fig. 2).

The patient was subsequently treated in a knee immobilizer and allowed to bear weight as tolerated. Two weeks later he reported for mountain warfare training in California and on examination there was found to have a normal knee.

After primary reduction, it is possible that the adult patient will sustain a second or repeated dislocations. For recurring dislocations of the proximal tibiofibular joint, two principal treatments have been proposed: arthrodesis or resection. Arthrodesis is frequently complicated by some limitation of motion at the ankle joint. Consequently, the preferred treatment is to resect the head of the fibula.

In summary, traumatic dislocation of the proximal tibiofibular joint is a diagnosis dependent on the physician's awareness and systematic physical examination. The condition is not found unless it is sought. Although relatively rare, a dislocated or unstable fibular head is common enough to warrant consideration in the evaluation of all injured knees.

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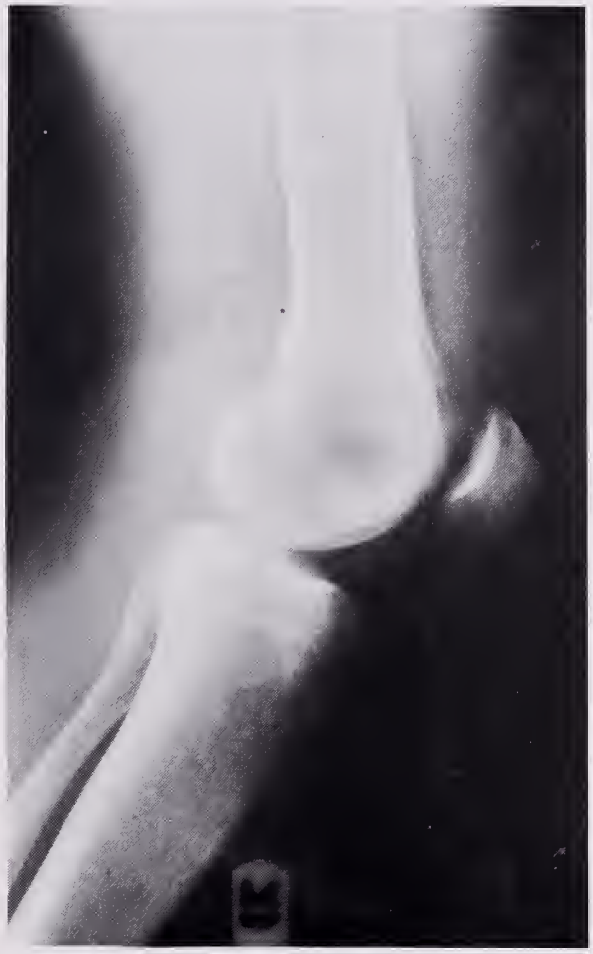

FIGURE 2: Lateral roentgenogram after reduction shows positioning of fibula in its normal relationship, slightly posterior to the tibia and immediately below the knee joint.

BRIEF REPORT

Commission on Association Affairs

The Commission on Association Affairs is delegated specific duties by the Board of Directors, and the Commission will then study these proposals, hold hearings, etc., and then report back to the Board of Directors. In the past, the initial proposals regarding a professional review organization in connection with the Nebraska Medical Association were first discussed by the Commission. Information then gathered by the Commission was forwarded back to the Board of Directors.

At the present time, the Board of Directors has asked the Commission on Association Affairs to look into the possibility of group insurance programs, group collection billing systems, group purchasing mechanisms, and so forth. A second area of study at this time is for the Commission to study health manpower in the state of Nebraska, working with the medical schools and their students in collecting this data.

The Commission on Association Affairs welcomes input in either of these areas or others that may be of interest to the membership.

Joel T. Johnson,
Chairman

WashingtoNotes

(Continued from page 12A)

has been no way to identify it. The new virus turns out to be a member of the retrovirus family. Such agents are now under intensive study because of their potential for effecting subtle but potentially serious changes in the immune system. One such retrovirus has been identified as the cause of the acquired immune deficiency syndrome, for instance, while others play a role in the development of human leukemias. The retroviruses are so-called because they have an enzyme called reverse transcriptase. This enables DNA to be assembled from an RNA template — the reverse of earlier classic thinking which had held that only DNA could make RNA.

The importance of the latest finding is that it will make possible a test to eliminate non-A non-B hepatitis from blood transfusions. Currently about 90% of post-transfusion hepatitis is caused by this new-found agent.

* * *

Most PROs Signed in October

With the PRO program pushing up against a November 15 deadline for implementation, federal officials at the end of October had signed contracts with PROs in 51 of 54 states or territories. Idaho, Hawaii and the Pacific Islands remained without a contract.

In Idaho, Health Care Financing Administration officials were pursuing a contract with the Medicare intermediary after a breakdown in negotiations with a subsidiary of the Idaho Medical Association. The intermediary, Blue Cross of Idaho, had reluctantly agreed to take the contract after attempts to assign Idaho reviews to a neighboring-state PRO failed. Staff of the medical association were to meet with federal officials before the contract with Blue Cross was finalized.

The Hawaiian and Pacific Islands contract had been expected to go to the California PRO contractor, California Medical Review, Inc. Snags were developing in those discussions, however, and the intermediary there (Blue Shield of Hawaii) had been alerted that it might be expected to assume the review responsibility.

(Continued on page 35)

President's Page

"MEDICINE IN TRANSITION"

THE LEGISLATIVE SCENE

Over the years medicine has found a remarkably increased number of issues in the legislative mill, both nationally and locally. Nationally, this trend started in approximately 1945. This included the Hill-Burton Act for hospital construction and expansion of medical schools; funds from this act brought the number of medical schools from 84 to 142. Not only did the government expand the number of health care facilities and the number of physicians, but also in 1954, the government made health care costs deductible from taxable income. This allowance was followed by direct assistance in the Medicare and Medicaid programs. In this open-ended era, health care became a God-given and government-given right. Following this long period of subsidies, cost pressures brought about federally subsidized health maintenance organizations and now a wage and price control scheme called DRG's. And, at the same time, the Federal Trade Commission has become active in the regulation of the professions. These legislative issues are increasing geometrically. The individual physician feels handcuffed.

There are things, however, that we can do to relate to these issues. First, we can become familiar with the issues. Second, we can know our representatives and communicate with them. Third, we can support concordant representatives directly and through our Local and National Political Action Committees (PAC). Fourth and probably most important, we must regain faith in our national medical leadership and support the American Medical Association so that we do have a strong unified voice.

On the state level, we also have seen ever increasing legislative issues: medical liability, certificate of need, and mandated insurance coverages, to mention a few. One of the remarkable increasing trends is licensure and regulation of a variety of health occupations. Today there are, at the least, 145 distinct health occupations and, probably, as many as 250 secondary alternative job titles. Fourteen of these are regulated in all states, and up to 45 separate health occupations are regulated in some states.

Herbert E. Reese, M.D.

There are three basic categories of non-physician health care providers: 1) The limited practitioners are those providers of health care of a limited scope who are licensed for independent practice (e.g. optometrists, chiropractors and podiatrists). 2) The largest group are allied health occupations. These jobs are the technical occupations which are generally under the direct supervision of physicians (e.g. laboratory and x-ray technicians, nurses, etc.). 3) The physician extenders are those practitioners who deliver direct patient care under established protocol and direct supervision of the practicing physician. This legislative session will see all of these three categories involved on the political scene in ever increasing numbers, which certainly has been a national trend. Some are asking for recognition, some for larger scope of practice and some for further independence.

There is an ever increasing trend to expand the scope of practice and independence of the non-physician health care provider by legislative means without the requisite medical training required of physicians. A reconsideration of the need for such regulation MUST be made. Is it the public or the regulated profession who benefits most from licensure? Four points have to be considered regarding the regulation of the health occupations: 1) What is the harm if unregulated? 2) What is the public benefit from regulation? 3) Are there means other than legislative regulation? 4) What is the impact of regulation on the cost of services to the consumer and the cost of implementation of proposed legislation?

Many of these tough issues will be in this legislative session as this year appears to be the year of Health Occupation Licensure. Physician support is paramount. We do have to become familiar with the issues. The NMA has already sent to you the deliberations of the Ad Hoc Committee on Health Policy Statements dealing with non-physician health care providers. This extremely well-written set of statements is invaluable and will be followed with further statements as they are developed. You will be posted regularly through the newsletter regarding these many legislative issues. After we know and understand the issues, we have to become conversant with our legislative representative regarding them. Most important, we must maintain that unified voice and support. The legislative session promises to be interesting, perhaps even surprising, but with your political support and with our emphasis on afforable quality medical care, I feel we can do what is best for the public and our patients.

Herbert E. Reese, M.D.

The Auxiliary

A TOTAL COMMUNICATION DAY THE FUTURE AND YOU

February 27, 1985

Villager Motor Inn
5200 "O" St., Lincoln, NE

8:30-10:00	Registration
9:00-10:00	Winter Board Meeting
10:00-11:00	Jerald Schenken, M.D. Chairman of AMA Council on Legislation "The Future and You"
11:15-11:45	Colo-Rectal Screening Ardis Grace, President-Elect, NMAA
12:00-1:30	Lunch Featured Speaker, the Rev. Patsy Moore, NMAA "Your Self Esteem" "Communication Through Legislation"
1:45-3:00	Anne Pitchford, El Paso, TX National Legislative Chairman of AMAA

Snow Date — March 6

Dear Auxiliary Friend,

I was very fortunate to attend the Leadership Confluence sponsored by the American Medical Association Auxiliary Oct. 14-16 at Chicago. I want to thank you for allowing me to go.

Some of the concerns were:

1. With the H.M.O.'s, P.P.O.'s, DRG's and all the other alphabet soup the government is laying on the physician and hospitals, everyone without exception is worried about the quality of care of the patient as well as their own personal income. It is estimated that 2,000 hospitals out of the 7,000 hospitals nation wide will fold and die within the next year. Some of these are small community hospitals and represent the only hospital within many, many miles.

2. One of the biggest concerns that was brought up and discussed for great lengths of time was the breakup of the medical marriage. The divorce rate nation wide for the medical marriage is 45%. Once you are divorced from your husband you no longer are a member of your auxiliary.

3. Getting members active is always a problem. Bev Kruger from Omaha stated that they have 800 possible members for their organization and only have 30 active. Active members experience a "burnout".

4. We have in a lot of the communities actual battles going on between the older physician and the younger highly specialized physician for patients. We have physicians not speaking to physicians and auxiliary members not speaking with each other. All communication lines are broken and as a result the quality of patient care decreases.

5. With all the government regulations and decreased income to the hospitals as well as the physician, in a lot of communities hospital administration is unwilling to communicate with the physician. We have another battle going on. But these hospitals where administration cannot talk or be friends with the physicians will fail.

6. The foreign physician was a concern in some communities especially in the south (Florida). These foreign physician wives refuse to become involved in the community — refuse to learn English. As a result their children are having a hard time adjusting. They are not accepted because they don't want to be accepted. The auxiliary members have tried many times to help them.

7. With the doctor glut we have communities who would have trouble supporting one super specialist now have many in the same field. I was talking to an auxiliary member from a city with a population of 100,000. She says there is

enough business to support one neurologist and they now have six.

There were twelve seminars we could pick from but time allowed us only to attend six. I have tapes that you can listen to on all of them. Most of them were excellent.

Legislation Issues and Ideas
Parliamentary Procedure
Working with the Media
All You Need to Know About Being a Leader
Time Management
Managing Conflict
Mid-Life Crisis - Dead End or New Opportunity
Prenatal and Postnatal Care
Child-Parent Relationships
Young Adolescent After School — Are They Surviving or Thriving
The Impaired Physician
Coping with Malpractice Problems

The president of the AMA spoke to us on health care in the U.S. He stated that nationwide less than sixteen percent of the physicians are accepting medicare assignment and that is good news. With the government becoming involved in patient care we will face the problems that Great Britain is experiencing where patients over 60 years are not allowed hip prosthesis and patients over 55 years are not allowed renal dialysis. Do you believe that we should ration care? Maybe we had better look into legislative issues.

Thank you again for sending me to this leadership Confluence.

Linda Brown, Hastings

In Memoriam

By medicine life may be prolong'd
yet death
Will seize the doctor too.
—Shakespeare

E. Howard Reeves, M.D. — (Born September 11, 1919 - died September 21, 1984) — Medical Specialty — General Practice. Doctor Reeves was a graduate of the University of Nebraska College of Medicine in 1946. He was a member of the American Medical Association and the Nebraska Medical Association. Surviving are his wife, Jean, of St. Edward; his stepmother, Mary Reeves of Madison; one daughter, Mrs. Don (Pamela) Brechbill, of Aurora; three sons, Jon of Gothenburg, Steven of Kearney and Mark of Scotia; one brother, Willis Reeves of Madison; a sister, Mrs. Willis (Iola) Becker of Raymond; and eight grandchildren.

Louis V. Brennan, M.D. — (Born September 3, 1908 — Died October 20, 1984) — Medical Specialty — General Practice. Doctor Brennan was a graduate of the Creighton University School of Medicine in 1934. He was a member of the American Medical Association and the Nebraska Medical Association. He is survived by his wife, and four sons, Pat and Terry Brennan of Falls City, Doctor Richard Brennan of St. Joseph, Mo., and Michael Brennan of Chillicothe, Mo.

Welcome New Members

Richard P. Bell, M.D.
2011 Lincoln Ave.
York, NE 68467

Coming Meetings

1985 ANNUAL SESSION — April 26-29 — Lincoln Cornhusker

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

CREIGHTON UNIVERSITY

CLINICAL ENDOCRINOLOGY & NEPHROLOGY FOR THE PRACTICING PHYSICIAN, Feb. 2-9, 1985, Ocho Rios, Jamaica. Program Director: Paul Steffes, M.D. For information: CME office (402) 280-2550.

CARDIOLOGY: STATE OF THE ART, Feb. 9-16, 1985, Puerto Vallarta, Mexico. Program Director: Syed Mohiuddin, M.D. For information: CME office (402) 280-2550.

CARDIOPULMONARY DISEASE, Feb. 16-23, 1985, Ocho Rios, Jamaica. Program Director: Walter O'Donohue, Jr., M.D. For information: CME office (402) 280-2550.

MEDICAL & SURGICAL ONCOLOGY FOR PRIMARY PRACTITIONERS & GENERAL SURGEONS, Feb. 23 - Mar. 3, 1985, Puerto Vallarta, Mexico. Program Director: James Mailliard, M.D. For information: CME office (402) 280-2550.

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 3-8, 1985. Sponsors: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 25 hrs. AMA Category I. Fee: $400 Physicians, $200 Residents. Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology, Endocrinology, Pediatric and Adult Cardiology.

UNIVERSITY OF KANSAS

For additional information on the following University of Kansas meetings contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, KS 66103, Telephone (913) 588-4480.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — February 21-22, June 13-14, 1985. Sponsor: University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 16 hrs - AMA Cat. I, 15 hrs. - AAFP. Fee: $600. Maximum attendance: 9.

CONTEMPORARY ISSUES IN OBSTETRICS AND GYNECOLOGY — January 20-26, 1985. Sponsor: University of Kansas Medical Center. Location: Sheraton Hotel, Ixtapa, Mexico. Credit: 20 hrs. AMA Category I, 18 Prescribed hrs. AAFP, 20 cognates, Formal Learning, ACOG. Fee: Registration and Land Package: Physicians $699, Spouses Attending Course $599, Spouses Not Attending Course $499. Registration only: Physicians $200, Spouses $100. Description: This year's postgraduate course will concentrate primarily (but not exclusively) on the surgical approaches to obstetrical and gynecological disorders. Some of the newer and most exciting techniques will be presented, but equal time will be given to the review of the latest modifications of older surgical procedures. Included in the non-surgical portion of the course will be discussions of psychological concerns confronting the physician, the nurse and the patient.

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 2-9, 1985. Sponsor: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 24 hrs. AMA Category I, 24 hrs. AAFP. Fee: $400 Physicians, $200 Residents.

Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology Endocrinology, Pediatric and Adult Cardiology. Contact Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Ave., Omaha, NE 68105, (402) 559-4152.

ADVANCED CARDIAC LIFE SUPPORT — March 20-21, 1985, May 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Building, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $150 physicians, $75 nurses, EMTs. Credit: 13.5 hrs. AMA Cat. I, 13.5 hrs. AAFP, American Heart Association Certification.

REHABILITATION MEDICINE: OFFICE MANAGEMENT OF MUSCULOSKELETAL PAIN SYNDROME — March 25-26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: Hours TBA for Physicians, Nurses, Physical Therapists.

COMMUNICATING WITH CHILDREN (HEARING AND SPEECH) — April 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians and Speech/Language/Hearing Clinicians.

35TH ANNUAL SYMPOSIUM ON ANESTHESIOLOGY — April 19-21, 1985. Sponsor: University of Kansas Medical Center. Location: Westin Crown Center Hotel, One Pershing Road, Kansas City, Missouri. Credit: 15.5 hrs. AMA Cat. I, 14 hrs. AAFP, 14 hrs. AANA. Fee: $225 Physicians, $150 Nurse Anesthetists.

11TH ANNUAL FAMILY PRACTICE SYMPOSIUM — April 24-25, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for physicians.

29TH ANNUAL SYMPOSIUM ON INFECTIOUS DISEASE — April 26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

ANNUAL PATHOLOGY SYMPOSIUM — April 27, 1985. Sponsor: University of Kansas Medical Center. Location: Rieke Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

SAM E. ROBERTS NUTRITION PROGRAM: MINERALS IN HUMAN NUTRITION — CLINICAL APPLICATION — April 30, 1985. Sponsor: Academy of Health Professions and University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $100 Physicians, $40 Nurses, Dietitians, Allied Health Professionals, no charge to students and residents. Credit: 7 contact hours each for physicians, nurses, dietitians, physical therapists, and respiratory therapists. Contact: Ida Tilden, Academy of Health Professions, 2920 McGee Trafficway, Kansas City, MO 64108, (816) 531-4559.

WashingtoNotes

(Continued from page 28)

The law specifies that hospitals which have not signed contracts with PROs by November 15 will not be paid by Medicare. In some states where the PRO contract was only recently awarded, negotiations between the PRO and hospitals have not been completed. Federal PRO officers have agreed that only those hospitals which are refusing to sign contracts will not be paid.

The officials still expect that contracts will have been awarded in all states by November 15. The bulk of contracts have gone to professional standards review organizations, coalitions of PSROs, or gorups that subcontracted with PSROs. About 40 contracts will involve a PSRO.

Nine medical societies (Maryland, Indiana, Missouri, Nebraska, New York, North Carolina, Oklahoma, Texas and Virginia) put together winning PRO bids. Medical societies in Michigan, Florida and California lost out to other bidders. The Florida Medical Association is protesting the award in their state; California had protested the bidding process but had not pursued the protest after the award was made to CMRI.

* * *

Cuts Threaten Medical Education, Congress Finds

Cost-cutting pressures among businesses, health insurers and the federal government are threatening the current method of funding medical education in the U.S. and could lead within just a few years to a situation in which the number of medical school graduates greatly exceeds the number of residency slots available to them.

This frightening possibility, raised at a Senate Finance health subcommittee hearing, is leading to a reassessment of the way graduate medical education is paid for today. It has led some, including subcommittee chairman Sen. David Durenberger (R-MN), to propose replacement of the present system, which is largely financed through patient care revenues, with an explicit public subsidy for medical education.

Many of those most intimately involved in medical training, including the American Medical Association, the Association of American Medical Colleges and the American Hospital Association, view such explicit federal funding as susceptible to political whim, however. They believe this type of subsidy would lack the stability that at least until recently had characterized the present funding method.

The issue came to the forefront during the development of Medicare's prospective pricing system and a recommendation by a Medicare advisory council calling for the "orderly withdrawal" of Medicare from the financing of medical education.

Durenberger, who plans a series of hearings on medical education, introduced legislation shortly before adjournment to replace the Medicare payment for the direct costs of medical education with a grant program.

At an opening hearing in early October, he said he believes the current reimbursement policies: result in some states' citizens paying to educate physicians who move to other states; may be providing a greater depth of knowledge than necessary; may encourage overproduction of surgeons and hospital-based specialists; can no longer be afforded by Medicare; and will also be rejected by the private sector as competitive plans such as preferred provider organizations steer members away from expensive teaching hospitals.

In view of these concerns, Durenberger predicted, the "direct graduate medical education pass through, as we know it, will be eliminated within two years, and the indirect adjustment for medical education expenses will require refinement." He called for "explicit government policies" to determine "who will take responsibility for graduate medical education and how much will we pay for it."

In defending the current financing arrangement, witnesses generally agreed that patient revenues have provided the dependable financing necessary to assure residents of the continuation of a training program throughout its three to seven year duration. They emphasized that the medical education allowance buys more than the training of health professionals, said it is impossible to completely separate the costs of medical education and patient care, and advised that even a better measurement of severity will not completely explain the higher costs associated with teaching hospitals.

All the witnesses urged that Medicare funding of medical education not be abandoned "precipitously" and both the AMA and the AHA stressed that some Medicare funding will continue to be necessary.

* * *

"Bad Docs" Bill Fails

Legislation to expand the federal government's authority to act against physicians disciplined by state medical boards or by Medicare or Medicaid will have to await action in a new Congress if it is to become law.

Rep. Henson Moore (R-LA) who introduced the measure (HR 5989) in the House had hoped to see it enacted prior to a scheduled October 5 adjournment of this Congress. Moore was able to push the bill through the House Ways and Means Committee, of which he is a member. A plan to take the measure directly to the floor of the House was thwarted, however, when the Energy and Commerce Committee refused to waive its jurisdiction and permit the bill to come up for a vote without action in the Commerce committee.

* * *

Congress Forwards HHS Appropriations Bill

Although it exceeds his budget request by some $5 billion, President Reagan is expected to sign a $104.6 billion appropriations measure that includes $79.6 billion for programs within the Department of Health and Human Services. Funding for HHS programs, which will increase by nearly $6 billion, includes:

* $410.5 million for the Centers for Disease Control and $5.15 billion for the National Institutes of Health.

* $922.6 billion for the Alcohol, Drug Abuse and Mental Health Administration, including $490 million for the mental health block grant and $196.2 million for mental health research.

* $234.5 million for training of physicians, nurses and other health professionals.

* $75 million for the National Health Service Corps field service and $360 million for community health centers.

* $478 million for the maternal and child health block grant.

* $16.3 billion for federal Medicaid grants to states and $17.9 billion for physician and other services covered under Medicare Part B. Medicare Part A is not included in the appropriations bill because it is funded through Social Security trust funds. Some $2.4 million will be taken from the trust funds to finance the Prospective Payment Assessment Commission.

* * *

DES Compensation Ruled by Supreme Court

The drug companies that manufactured the drug diethylstilbesterol (DES) must share the cost of compensating victims of their product, according to a state court ruling upheld in October by the U. S. Supreme Court.

The high court justices, without comment, refused on October 1 to hear an appeal by E. R. Squibb and Sons, Inc. of a Wisconsin supreme court ruling that all manufacturerers should be held responsible for damages caused by the drug.

The 1,000 victims of DES who have filed suits have been frustrated in their efforts to collect damages, because they cannot prove the origin of drugs taken 20 to 30 years ago.

* * *

Drug Warnings Upheld

Drug companies must warn physicians and patients about the dangerous side effects of its products, according to a state court ruling upheld this month by the U.S. Supreme Court.

The high court justices, without comment, refused to hear a challenge to a Kansas court decision by Ortho Pharmaceutical Co. The company argued that it was not bound legally to warn doctors or patients of rare side effects caused by the contraceptive pill.

Carol Lynn Wooderson of Lawrence, KS, suffered hemolytic uremic syndrome after taking Ortho-Novum 1-80 between 1972 and 1976. As a result, she underwent two kidney transplants, intestinal surgery, and cataract surgery for problems caused by the drug.

Wooderson was awarded a total $4.7 million settlement, with $2 million for suffering and medical expenses, and another $2.7 million in punitive damages against Ortho.

In the ruling upheld by the Supreme Court, the Kansas court said that drug manufacturers have a duty to warn "the medical profession of dangerous side effects of its products which it knows, has reason to know, or should know." Ortho should have listed the kidney disease on the package as a "suspected side effect," it said.

* * *

President Vetoes NIH Authorization BIll

President Reagan this month vetoed a bill that would have made several important changes in the structure and management of the National Institutes of Health (NIH), thus delaying for another session of Congress any plans to create a new arthritis institute, nursing institute, and numerous other small disease commissions.

In a statement accompanying his veto of S540, the Health Research Extension Act, the President contended that the bill created unnecessary and expensive new organizations, required overly specific management requirements, and went far beyond its mission by rewriting all relevant statutes of NIH.

President Reagan said his veto will not affect NIH funding for FY 1985, since money to support the institutes was included in another spending bill, already passed and signed.

The structural changes, which were the first major attempt in years to alter the way NIH does business, would have created:

* an Arthritis Institute, to focus increased attention on the joint and connective tissue disorders that afflict 40 million Americans;

* a Nursing Institute, which would have linked nursing research closer to the mainstream of scientific investigation in other health care disciplines; and

* fetal research provisions, including a moratorium on the government's ability to waive risk standards for certain types of fetal research thus restricting experimentation in this area.

* guidelines for the proper care and treatment of animals used in biomedical and behavioral research, giving NIH the authority to revoke funding if a lab failed to meet the guidelines.

A veto had been urged by NIH director James Wyngaarden, M.D., officials at the Department of Health and Human Services, and the AMA.

* * *

Reagan Kills Manpower Bill

Carrying through on an earlier threat, President Reagan has vetoed an omnibus bill reauthorizing health professions assistance, nurse training, the National Health Service Corps and community health centers.

In his veto message, the President said the measure would have "continued and increased obsolete federal subsidies to health professions students" at a time when the "surplus of physicians has reduced the need for federal financial incentives."

The message also noted, however, that a continuing resolution approved by Congress just before adjournment "provides adequate authority for the continuation" of the programs in the vetoed bill. In fact, the President's veto is expected to make little difference to the current operation of the programs which with or without the veto were to be funded at FY 1985 appropriations levels.

The veto will force Congress to reconsider the manpower programs again next year, however, and it signals a new battle to limit federal support of manpower programs and give the White House greater control over their funding.

Congressional committees had anticipated a veto during their later deliberations on the manpower measure and had made several cuts in funding authorizations in an attmept to stave off the veto. Total funding for all the reauthorized programs in fiscal 1985 was about $740 million, with about $158 million of that allocated to health professions assistance. The measure also included a study of Rep. Ron Wyden's (D-OR) proposal to have the Public Health Service give technical assistance to groups that collected and interpreted health care data.

The White House had also sought to replace current categorical grants with an omnibus authorization to be divided up at the discretion of administration officials. This Office of Management and Budget proposal had never been formally introduced as legislation but Reagan cited the continuation of "the rigid and categorical framework" of health professions grants as one reason for his veto. He also claimed that the reauthorization funding levels ($2.4 billion through 1987) were still far in excess of his budget request ($1.7 billion).

* * *

Organ Transplant Bill Enacted

With storybook style, Congress came to the rescue of the nation's beleagered organ transplant system, pulling it to its feet with over $31 million in grants and two major task force reports.

It was not without last-minute hesitancy: faced with a deadlock, they deleted controversial provisions that would have paid for cyclosporin and restricted transplant procedures to eligible patients, physicians, and hospitals.

Nonetheless, their agreement — passed by the House on October 3 and the Senate on October 4, then signed by President Reagan later in the month — represents a major effort to close the gap between federal law and new medical technologies.

The bill has four major provisions:

—a report on the safety, efficacy, cost and reimbursement status of the immunosuppressive medications that prevent organ rejection, to be presented to the Department of Health and Human Services within 7 months for further action;

—an analysis of medical centers now performing transplants to determine whether they are under or overabundant, well-distributed around the country, and accessible to the public, to be released to HHS within 12 months for further action;

—$25 million in grants to support the planning, establishment, and expansion of organ procurement organizations; and

—$2 million a year to set up a 3-year national Organ Procurement and Transplantation Network, which would match organ donors and recipients.

Also included is a measure that outlaws the buying and selling of organs, except replenishable tissues such as blood or sperm.

* * *

Anti-Quack Campaign Launched

A national public information campaign was launched in October to combat the bogus health devices and drugs that cost consumers an estimated $10 billion every year.

More than 4500 advertising agencies and 1000 health care companies have been asked by the Food and Drug Administration to enter an advertising contest to warn the public about the hazards of "miracle" weight reducers, arthritis and cancer cures, baldness remedies, phony sex aids, bust expanders, and fake "fountains" of youth.

The three best submissions will be selected to appear on television, on radio, and in national newspapers and magazines. Contenders are asked to volunteer their efforts, but a $170,000 fund created by 20 drug companies will help offset other expenses.

The contest is supported by the AMA, the American Pharmaceutical Association, and the National Council of Better Business Bureaus.

* * *

Other Washington Happenings in October

* Congress approved and President Reagan signed a bill that will help resolve claims for veterans' benefits based on exposure to herbicides or radiation.

* The Senate refused to ease restrictions on

federal funding of abortions for poor women, voting 54 to 44 to offer assistance only when the mother's life is at stake.

* Congress approved a study of the feasibility of developing a "safe" cigarette that would not ignite upholstered furniture or mattresses. The bill signed by President Reagan, requires an interim report within a year and final report within 2½ years.

* A National Institutes of Health advisory committee rejected a proposal to ban experiments in which genes are transferred from one animal species to another.

* Food and Drug Administration advisory panel recommended that the injectible contraceptive Depo Provera not be approved for sale in the U.S.

* The Supreme Court agreed to decide whether states may require companies to provide mental health benefits in their employee plans.

* A National Institutes of Health concensus conference concluded that most uses of fresh frozen plasma (FFP) are unwarranted and may place the patient at risk of viral hepatitis or AIDS.

* Edward N. Brandt Jr., M.D., announced his resignation as Assistant Secretary for Health at the Department of Health and Human Services (HHS) to become Chancellor of the University of Maryland at Baltimore in 1985.

* Army Surgeon General Bernhard Mittemeyer, M.D., announced that he will leave his position in early 1985 to become vice president and medical director of a Los Angeles-based medical management firm.

* John W. Ditzler, M.D., was selected as the new chief medical director of the Veterans Administration, succeeding Donald L. Custis, M.D.

* * *

Rate Setting Said to be Cost-Saving

State rate setting programs in four states where Medicare has waived its regular reimbursement rules to participate in the state program are saving Medicare $1 billion a year, according to projections from the Johns Hopkins Center for Hospital Finance and Management.

The findings were announced at a Washington, DC, press conference by a new coalition of groups pushing for expansion of similar rate setting programs to other states. The coalition's immediate interest is in assuring continued Medicare participation in the four currently waivered states and publication of regulations that would permit other states to apply for waivers.

Eleven states (Connecticut, Florida, Maine, Rhode Island, Washington, West Virginia, Wisconsin, Maryland, Massachusetts, New Jersey and New York) have some form of mandatory rate setting apparatus but Medicare participates in only the latter four. The Medicare diagnosis related groups (DRG) prospective pricing system applies in all other states.

Congress specified in the DRG law the conditions under which state systems may be exempted from the federal system and several states — including Connecticut, Maine, West Virginia, Washington, and Wisconsin — are expected to apply for waivers. As many as 16 states are likely to consider rate setting plans next year.

The Administration's failure to issue the waiver regulations some 19 months after passage of the law has tended to confirm rumors that White House budget officers want to squelch these and other waivers in the belief they raise federal costs. A key test will come in late November when a decision is due on a new waiver application from New Jersey.

New Jersey, which pioneered the use of DRGs under a waiver that began in 1980, calculates that continuation of a waiver could save Medicare $126 million over three years. In the first year, however, the waiver is expected to cost Medicare $28 million more than the national scheme would have. New Jersey hospitals have offered to forego one round of Medicare advances to assure that the federal government does not lose money in any year.

Although waiver expirations are not imminent in the other three states, continuation of waivers there was challenged earlier this year by a Federation of American Hospitals study which claimed increased payments in the waivered states were costing hospitals in other states $36 a case. Other have argued that even if rate setting does hold down overall costs, Medicare participation in such plans may raise federal contributions by forcing Medicare to pick up a share of bad debt it had previously avoided.

Although hospital officials in the waivered states have castigated the FAH study and motives, they are under pressure to show that their systems do work and in particular that Medicare will not lose under these systems.

They have thus teamed up with commercial health insurance industry, groups representing the elderly and organized labor to form a new Coalition of State All-Payers Hospital Payment Systems. Members include hospital and rate setting officials from the four waivered states, Blue Cross plans in the four states, the Health Insurance Association of America, the American Association of Retired Persons, the National Association of Public Hospitals and the AFL-CIO.

The new coalition claims that even Medicare saves money under the rate setting plans. The Hopkins study, whose details are being withheld pending publication, projected that if waivers had been in place in all four states for all of 1982 and 1983, Medicare savings would have amounted to about $1 billion a year.

The group also argues that rate setting plans in which all payers participate represent the best hope of dealing with the problem of how to compensate hospitals for care provided to uninsured and indigent patients.

Groups which oppose a federally-mandated all-payer approach are the FAH, the American Hospital Association, the Blue Cross and Blue Shield Association and the American Medical Association. The AHA does favor the state waiver option, however, and the AMA has suggested that rate setting proposals "be examined at the state level."

* * *

Post-Election Wrapup

President Reagan's landslide victory is unlikely to make a major difference in physician's professional lives as both the newly-elected Congress and the returning administration continue to chip away at costs in an industry that is seen as a key part of any effort to reduce the federal deficit.

Presidential advisers are terming the vote a mandate for continuation of Reagan policies which appears to signal a continuation of efforts to reduce spending for social programs — including Medicare and Medicaid.

Others contested the contention that the President has won a mandate and pointed to the President's failure to convince the voters to give him a "working majority" in the Congress.

The GOP regained only 14 of the 26 seats that it needed to restore a coalition of Republicans and conservative Democrats that combined to push major Reagan initiatives through Congress before the mid-term election reduce Republican numbers in the House. The Democrats will have a 71 seat majority. In the Senate, Republicans retained control but Democrats picked up two seats, reducing the Republican edge in that body to 53 to 47 in the new 99th Congress.

Thus, while the President can expect a slightly more cooperative House of Representatives, his support in the Senate has been slightly diminished. Although the Democratic to GOP balance on House committees may be minimally altered, the shift is not expected to have a major impact on control of the committee process by Democrats.

Perhaps the major change resulting from the elections is the retirement of Senate Majority Leader Howard Baker and the ascension of Kansas Republican Robert Dole to the leadership post. Dole has a reputation for speaking back to the White House and under his guidance, the Senate could prove more independent than under Baker.

Dole will be relinquishing his key chairmanship of the Finance Committee to Senator Robert Packwood, a moderate Republican, who has sometimes been regarded as a maverick. He has generally supported and been supported by organized medicine.

As head of the Senate Commerce Committee, however, Packwood did oppose the American Medical Association's effort to eliminate Federal Trade Commission controls over the professions. He is an opponent of taxes on employer-paid health insurance premiums and of restrictions on a woman's right to an abortion.

Most other important transformations in Congressional panels with jurisdiction over health legislation also occur as a result of retirements. On the House Ways and Means Committee, two Democrats — James Shannon of Massachusetts and Kent Hance of Texas — are retiring. So are Republicans Barber Conable of New York and Jim Martin of North Carolina. In line to step up to the widely-respected Conable's ranking minority spot is John Duncan (R-TN) who has been a friend to health providers but may not have the influence Conable did.

On the House Energy and Commerce Committee, three seats are changing. New York Democrat Richard Ottinger and Illinois Republican Tom Corcoran retired. Tennessee Democrat Albert Gore Jr. will move to the Senate where he won the seat of retiring Senate Majority Leader Howard Baker (R-TN). Gore, who frequently used his post on the Oversight and Investigations subcommittee to conduct hearings into controversial medical issues, played a major role in the passage of an organ transplant bill that was initially opposed by the American Medical Association but was modified in later Congressional deliberations.

Other Senate changes of some interest to the health industry include the retirement of West Virginia Democrat Jennings Randolph who served on the Labor and Human Resources Committee and the defeat of Republicans Charles Percy (IL) and Roger Jepson (IL). Randolph had backed the National Health Service Corps, community health centers and other programs to aid his depressed state. Percy, had chaired a Governmental Affairs Subcommittee, that occasionally dealt with health issues. Jepson had headed the joint economic committee which also sometimes took up health matters.

* * *

Budget Cuts Planned for Health

Among a host of health-related budget proposals Reagan Administration health and budget advisers are pondering for fiscal 1986 is a continuation of a Medicare freeze on physician fees.

All budget discussions at this point are in preliminary stages and White House officials say no mechanics of a freeze have been worked out. It is not even clear, for instance, that the freeze would cover all physicians. Nor have any final decisions been made on which of a laundry list of possible health program cuts will be included in the plan the President will send to Congress in late January or early February. But the President has told his staff that deep cuts will be made in all discretionary programs and a freeze on all government programs except Social Security.

In addition to the physician fee freeze, a variety of other previously-offered administration health budget initiatives are expected to be on the platter for next year as well. These include a number of recommendations from the conservative Heritage Foundation, which has close ties to the administration, as well as some that Congress has rejected in the past.

The Heritage Foundation, which has distributed a thousand-page report to the Reagan cabinet, wants to "modify" Medicare's diagnosis related groups price controls through the addition of provisions intended to enhance market competition.

All were offered in the President's first term but never garnered adequate support in Congress. They include a proposal to improve Medicare coverage for catastrophic illness while increasing cost-sharing for shorter hospital stays; Medicare vouchers; and a tax on employer-provided health benefits above a certain limit.

The tax cap, which has substantial opposition in Congress, would reduce current subsidies estimated to cost the federal government $17.6 billion in lost revenues. Medical expense write-offs reduce federal income by another $3.2 billion and charitable contributions to health organizations another $1.4 billion. All three could be eliminated in a simplified tax plan the Treasury Department is developing.

The cost-sharing portion of the catastrophic illness benefit also faced major difficulties in Congress and the provision budget officers are considering this year reportedly would set up a new premium to cover the cost of catastrophic

(Continued on page 13A)

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WashingtoNotes

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coverage. Another possibility is to require private employers to include catastrophic protection in workers' health insurance.

The voucher proposal is also said to be on the budgeteers' list along with increases in the part B premiums and deductibles and major changes in the funding of graduate medical education. The latter could include replacing the current Medicare contribution to the direct cost of medical education with a block grant and discontinuing the indirect cost allowance for all but the largest teaching hospitals.

Medicaid, which was hard hit in earlier rounds of budget cutting, could also be hit again, although Congress may balk at any further cuts in this program. Possibilities include: a 3% reduction in federal Medicaid payments to states where "health costs are excessive when compared to nationally established growth rate targets"; changes in the matching payment formula; or an across-the-board reduction in federal payments.

* * *

Appropriations, Hospice Home Care Bills Signed

As one of his first post-election duties, President Reagan signed on November 9 a $79.6 billion appropriation bill for the Department of Health and Human Services and a measure raising Medicare rates for hospice home care.

The appropriations measure which funds HHS programs through October 1, 1985,

(Continued on page 14A)

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(Continued from page 13A)

includes money for the National Institutes of Health and Human professions education programs that will continue despite the President's earlier veto of bills reauthorizing these programs. The NIH is to receive $5.15 billion; nurse and health professions training programs, $234.5 million.

The hospice bill would restore the home care payment to $53.17 a day. HHS had initially proposed this rate but reduced it to $46.25. A veto threat was withdrawn in the face of the considerable public and bipartisan Congressional support for the hospice movement.

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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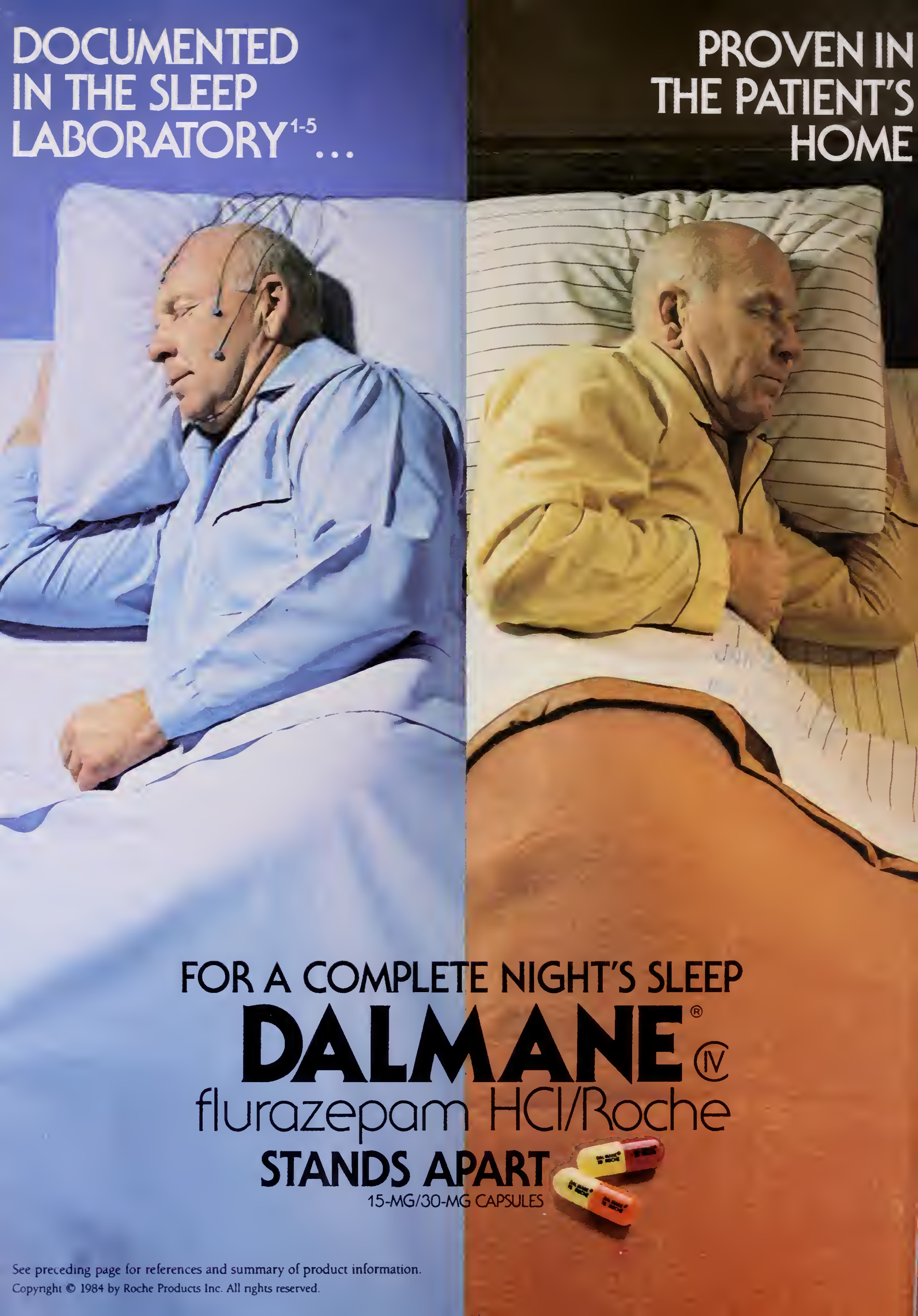
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WashingtoNotes

HHS Savings in Medicare

The Department of Health and Human Services expects to save an estimated $3.7 billion over the next five years as a result of actions taken in 1984 on recommendations of the Department's Inspector General.

The savings represent a $58 return on each dollar spent by the IG's office.

Detailed in the IG's year-end report to Congress, most of the $3.7 billion is estimated future savings from program changes legislated or implemented at the recommendation of the IG. The remainder is due to recoveries and fines imposed on program beneficiaries, providers and contractors.

The bulk of the savings — which are 166% higher than those of the previous year — occur as a result of legislative changes in the Medicare and Medicaid programs, particularly those affecting payments to clinical laboratories. They also include recoveries of inappropriate or fraudulent charges and fines for fraudulent or abusive behavior.

Some 900 individuals were prosecuted for attempting to defraud HHS programs and another 400 convictions were obtained by state Medicaid fraud control units. Of these, 327 health providers or suppliers were "kicked out" of Medicare and Medicaid and $7.5 million was recovered in settlements under the Civil Monetary Penalties Act.

The report also recommends other program changes the IG contends could result in further savings. These include a mandatory second opinion program and a plan that would round down to the next lowest dollar any odd penny claims from patients or their doctors for Medicare-covered physician services.

* * *

ANNOUNCING

117th Annual Session, Nebraska Medical Association

April 26-29, 1985

NEBRASKA ALLERGY SOCIETY

The objective of this course is to review current controversies regarding the treatment of asthma. This will include the use of theophylline and metaproteranol.

AMERICAN CANCER SOCIETY

This course will present the most common cancer in the State of Nebraska, colo-rectal cancer. The objective of this course is to emphasize early detection and treatment of colo-rectal cancer, an effort which can return three out of four patients to normal active lives.

MISSOURI VALLEY DERMATOLOGIC SOCIETY

The diagnosis and treatment of common dermatologic problems which would be encountered by the practicing clinician will be presented and divided into three areas. These areas will include pediatric dermatology, dermatologic surgery and common dermatoses; the focus of the discussions will be toward the practical approach to cutaneous entities in each of these categories.

NEBRASKA HEART ASSOCIATION, LINCOLN DIVISION, and the NEBRASKA CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

This course is designed to review both cardiac and pacemaker arrhythmias with emphasis on diagnosis and treatment. In addition, cost effective evaluation of dysrhythmias as well as pacemaker indications will be presented. There will be discussion on pharmacologic agents as well as drug interactions. This course is aimed at both primary care and subspecialty physicians who deal with cardiac patients.

NEBRASKA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

The objective of this course is to update the primary care physician in areas of adolescent medicine.

NEBRASKA ACADEMY OF OPHTHALMOLOGY

The general topic of this course will be Strabismus. The speaker will be William E. Scott, M.D., Professor of Ophthalmology, Department of Ophthalmology, University of Iowa Hospitals and Clinics, Iowa City, IA.

NEBRASKA ACADEMY OF OTOLARYNGOLOGY

The title of the program will be "Management of Cancer in the Neck." This course will cover the management of metastatic squamous carcinoma of the neck, including N_0 neck. Different modalities of cervical lymph node dissection will be discussed, including the indications and technique of the functional neck dissection.

NEBRASKA RADIOLOGICAL SOCIETY

This course is designed to present topics of current interest to practicing radiologists.

NEBRASKA CHAPTER, AMERICAN COLLEGE OF SURGEONS

This course is designed for Candidates and Fellows of the American College of Surgeons to act as a forum for presentation of papers of current interest.

NEBRASKA MEDICAL ASSOCIATION AUXILIARY

The Auxiliary-sponsored portions of the Annual Sesion will include its Annual Board Meeting on Friday morning, a progressive dinner Friday evening, the brunch and presentation of awards Saturday morning, a meeting of the Gavel Club Friday afternoon, and the meeting of the new Board on Sunday.

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PRO Contracts Complete, Feds Bid Out Super PRO

With just six days to spare before a Congressional deadline for implementation of the fledging peer review organizations (PROs), Health Care Financing Administration officials on November 9 signed the last three PRO contracts.

The officials now are awaiting bids for another contract — dubbed the Super PRO — to evaluate and monitor the PROs.

Also still to come are four sets of PRO regulations that have not yet been issued in final form.

As had been predicted, Idaho will be the only state in which the review authority has been delegated to a Medicare intermediary. There, the Idaho Blue Cross plan will be paid its cost for the PRO reviews of hospitalized Medicare patients' care. A $1.3 million spending limit has been placed on the contract, however.

(Continued on page 18A)

Share An Evening With The President

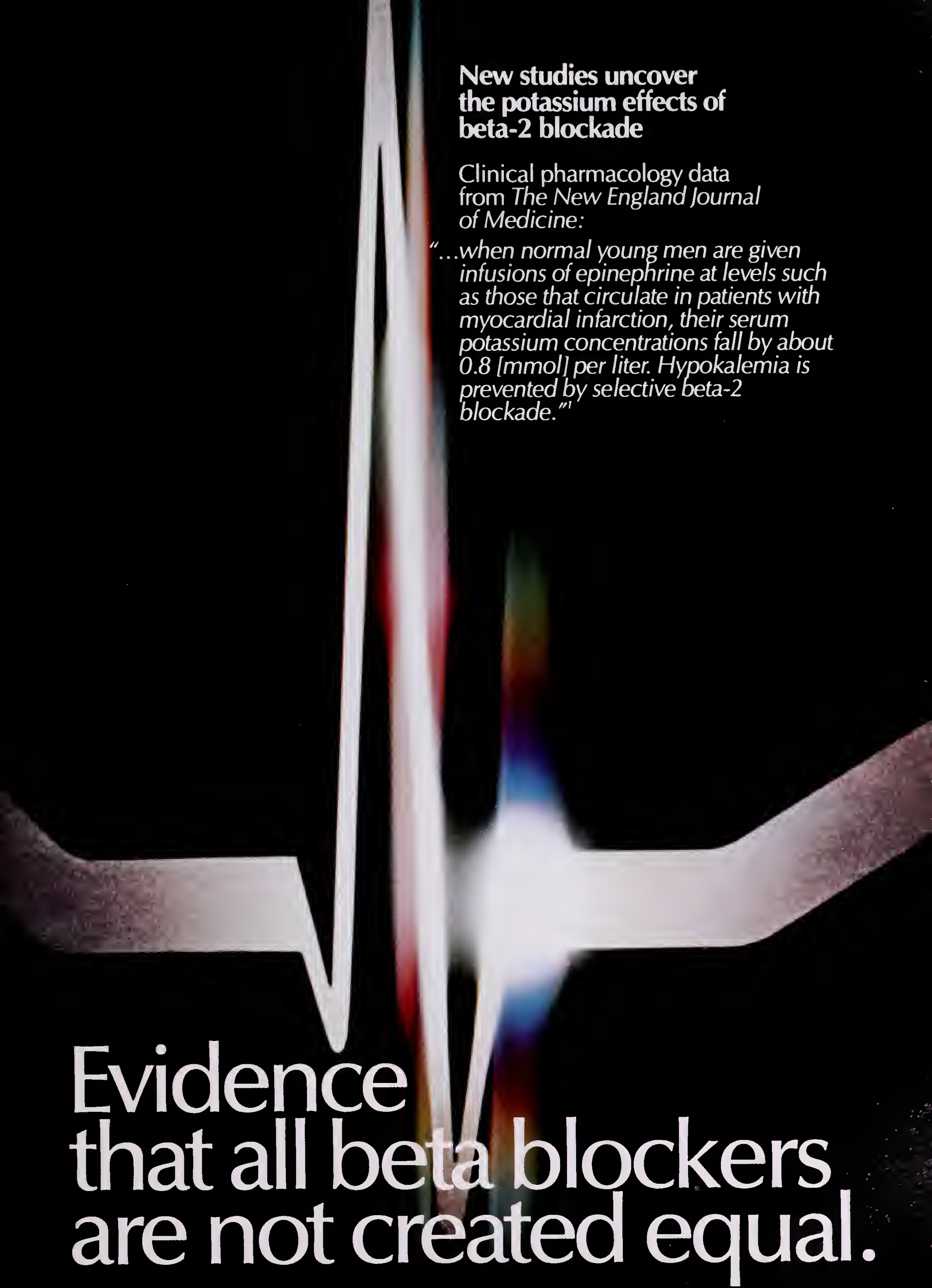
at the annual Inaugural Banquet, 1985 Annual Session
Nebraska Medical Association
Cornhusker Hotel, Lincoln, Nebraska
April 28, 1985

Guest Speaker
Joseph F. Boyle, M.D.
President
American Medical Association

Dr. Boyle

Physicians and their spouses are urged to plan attendance at the Inaugural Banquet as one of the highlights of the 117th Annual Session. Dr. Frank D. Donahue will be installed by Dr. Herbert E. Reese to launch the new year for the Nebraska Medical Association.

Dr. Boyle is a veteran leader in the AMA who has also been highly honored for leadership in his specialties--internal medicine and diseases of the chest. His community and state-wide leadership from his home in Los Angeles, and ten years experience on the AMA Board of Trustees, provides him with an excellent base from which to speak with authority on the critical issues facing medicine today.



New studies uncover the potassium effects of beta-2 blockade

Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block greater than first degree beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of
receptor agonists and its effects can be reversed by administration of such agents
dobutamine or isoproterenol However, such patients may be subject to protracted s
hypotension Difficulty in starting and maintaining the heartbeat has also been reporte
beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the
pearance of certain premonitory signs and symptoms (pulse rate and pressure change
acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be
difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyro
Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp
of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have
reported in which, after propranolol the tachycardia was replaced by a severe bradyc
requiring a demand pacemaker In one case this resulted after an initial dose of
propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with imp
hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatm
hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Pa
should be told that INDERAL may interfere with the glaucoma screening test Withdrawa
lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart dis
elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as
pine should be closely observed if INDERAL is administered The added catechola
blocking action may produce an excessive reduction of resting sympathetic nervous a
which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ortho
hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals
been conducted to evaluate toxic effects and carcinogenic potential In 18-month stud
both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi
drug-induced toxicity There were no drug-related tumorigenic effects at any of the d
levels Reproductive studies in animals did not show any impairment of fertility tha
attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryoto
animal studies at doses about 10 times greater than the maximum recommended human

There are no adequate and well-controlled studies in pregnant women. INDERAL s
be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised
INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and
rarely required the withdrawal of therapy

Cardiovascular bradycardia congestive heart failure, intensification of AV block
tension, paresthesia of hands, thrombocytopenic purpura arterial insufficiency, usually
Raynaud type

Central Nervous System lightheadedness, mental depression manifested by ins
lassitude weakness, fatigue, reversible mental depression progressing to catatonia
disturbances, hallucinations, an acute reversible syndrome characterized by disorientat
time and place, short-term memory loss, emotional lability, slightly clouded sensorium
decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting epigastric distress, abdominal cramping, dia
constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with a
and sore throat laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis nonthrombocytopenic purpura, thrombocyto
purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has
reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male
tence, and Peyronie's disease have been reported rarely Oculomucocutaneous rea
involving the skin, serous membranes and conjunctivae reported for a beta blocker (pra
have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlori
sustained-release capsule for administration once daily If patients are switched from IN
tablets to INDERAL LA capsules, care should be taken to assure that the desired thera
effect is maintained INDERAL LA should not be considered a simple mg for mg substit
INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitratio
be necessary especially to maintain effectiveness at the end of the 24-hour dosing in

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is
INDERAL LA once daily, whether used alone or added to a diuretic The dosage m
increased to 120 mg once daily or higher until adequate blood pressure control is ach
The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage
mg may be required The time needed for full hypertensive response to a given dos
variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDER
once daily, dosage should be gradually increased at three to seven day intervals until op
response is obtained Although individual patients may respond at any dosage lev
average optimum dosage appears to be 160 mg once daily In angina pectoris, the valu
safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued reduce dosage gradually over a period of a few
(see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDER
once daily The usual effective dose range is 160-240 mg once daily The dosage m
increased gradually to achieve optimum migraine prophylaxis If a satisfactory respons
obtained within four to six weeks after reaching the maximum dose, INDERAL LA t
should be discontinued It may be advisable to withdraw the drug gradually over a pe
several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group
limited to permit adequate directions for use

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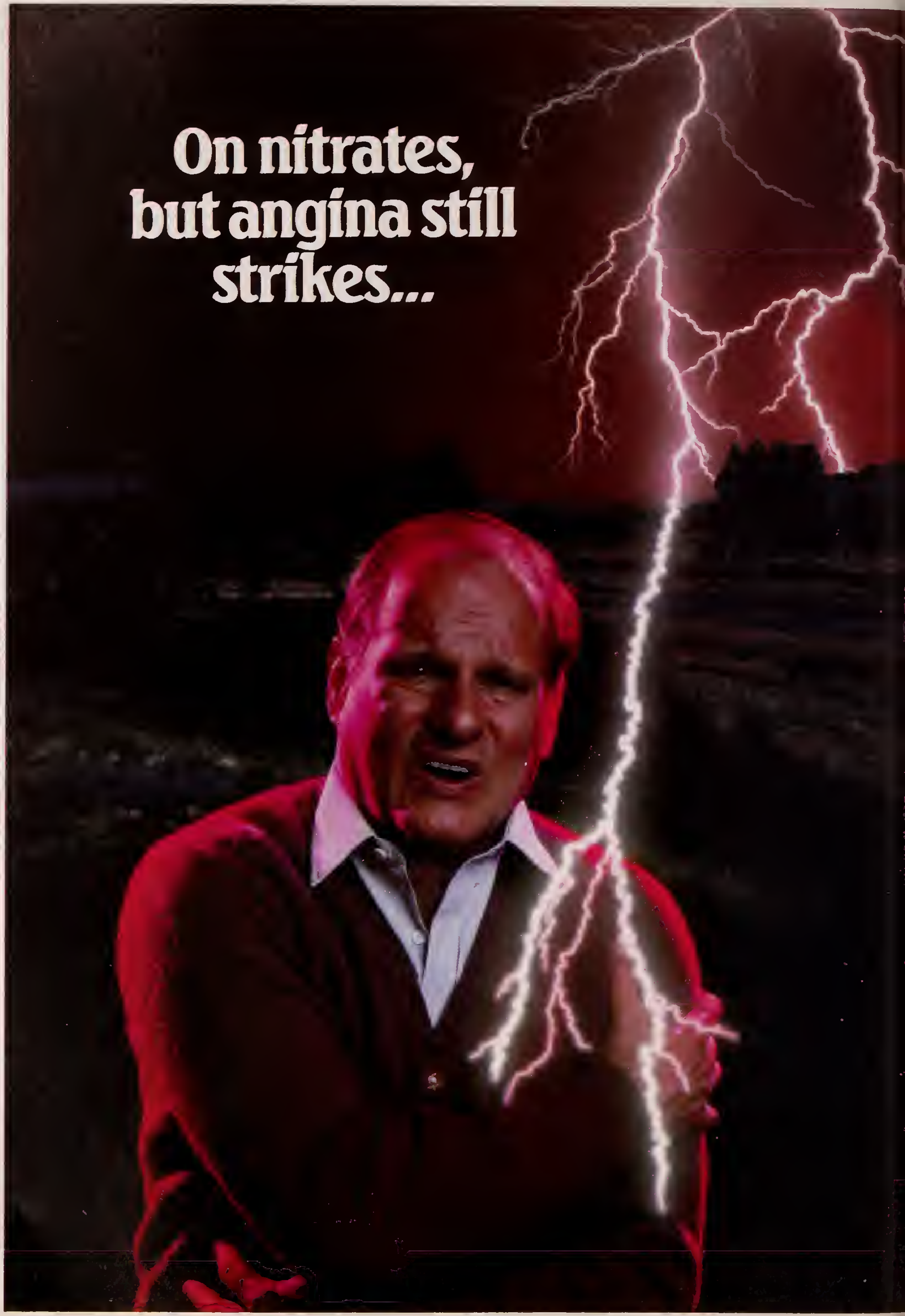
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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

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80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C.* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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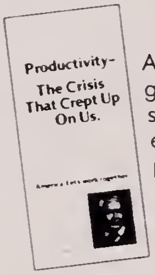

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Employee leasing now possible for Physicians

People have now joined the ranks of business necessities which can be acquired by lease. The concept was made feasible by provisions in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), said Elvin D. Talbot, vice president of First Employee Leasing Ltd. of Omaha.

The firm is a sister of Omaha's Help Inc. Both are headed by Wendell S. Haack.

The plan appeals to employers, said Talbot, because it not only relieves them of preparing the payroll for the leased employees, but it makes it possible for them to, in effect, provide pension plans at different percentage levels for management and support personnel. That is not legally possible when all employees are hired directly by the company in whose offices they are working.

For the leased employees, the program at First Employee Leasing offers immediate participation and vestiture in a pension program to which the employer contributes 7.5 percent of the employee's annual income, said Talbot. Employees can add an equal amount if they choose.

Talbot

As the number of leased employees grows at First Employee Leasing, "it will lend a degree of job security," said Talbot. "If an employer goes out of business or moves to Phoenix, I can take those employees and place them."

Since opening June 1, First Employee Leasing has hired, then leased back existing support employees of 10 client firms ranging from manufacturers to physicians, dentists, attorneys and accountants. No employees have terminated their jobs as a result of the changeover, Talbot said.

Funds in the employee pension plan are held by a trustee and cannott be diverted by the employee leasing firm, he said. With support personnel provided for through the leasing company, company managers may then set up a pension program at a higher rate of contribution since they remain as the only true employees of the firm.

As an example of how the leasing program works, when XYZ Co., a moderate sized manufacturing firm, decides to lease its line workers and support office personnel, that firm contacts First Employee Leasing or another firm offering a similar program. First Employee Leasing hires XYZ Co.'s line workers and pays their wages as well as such statutory taxes as the social security tax and worker's compensation, and makes a contribution to the company pension fund on behalf of each employee in the amount of 7.5 percent of that employee's annual earnings. In return, the lessor pays a flat fee for the lease of each employee. The leasing fee usually runs from 30 to 37 percent of the salary base, roughly the equivalent of the cost of normal employee benefits.

With the managers remaining as the only employees, they could establish their own pension plan at a rate of up to 25 percent of their annual earnings at the company. Or, if the proprietor was the only unleased employee, he could join the 7.5 percent pension fund of his leased employees and invest up to an additional 17.5 percent of his annual earnings (a total of 25 percent is the highest allowable amount) in a separate pension fund of his own choosing or through another fund handled by First Employee Leasing.

The leasing arrangement is not viewed by Talbot as practical for high turnover jobs and he said that First Employee Leasing will concentrate its marketing on companies with stable support staffs.

Employee leasing is not likely to appeal to large companies which, because of their size, would need to continue to operate in-house many of the services which First Employee Leasing offers, said Talbot.

"To do a good job, 100 employees would be the maximum (per client company)," he said. "I would be more comfortable with 50." When his firm hires employees for leasing to their current employers, each person is interviewed individually to explain the transition, Talbot said. "I become a friend of the employees," he said. "There is a very important transition. It is also very important that the employer recognizes and is comfortable with me."

As original employees leave and are replaced or as client companies expand, client companies continue to have the final word on whether they lease a given employee. "In time, we will have the capacity to hire, interview, test and train, but the level of First Employee Leasing is not to determine whether an employee has the capacity for the job," said Talbot. "The employer still must maintain the technical control of the employee's work."

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WashingtoNotes

(Continued from page 6A)

HCFA negotiators had initiated talks with the Hawaiian intermediary, Blue Shield of Hawaii after a plan to have the California PRO assume review in Hawaii and the Pacific Islands fell through. Negotiations with the Arizona PRO proved more successful, however, and that contractor was also awarded the $1.28 million Hawaiian contract and the $227,000 contract for Guam and Samoa.

The Arizona PRO (the Phoenix-based Arizona Health Services Advisory Group) is one of only two for-profit groups that won PRO contracts. The other is the Pennsylvania Peer Review Organization in Camp Hill.

Meanwhile, federal officials are gearing up to keep a watchful eye on the PROs. The new review organizations have considerably more authority than their predecessor Professional Standards Review Organizations, and HCFA staff is concerned that the PROs apply their power with sensitivity. There have been a few early reports of impolitic actions and letters among some PROs that have probably un-

(Continued on page 20A)

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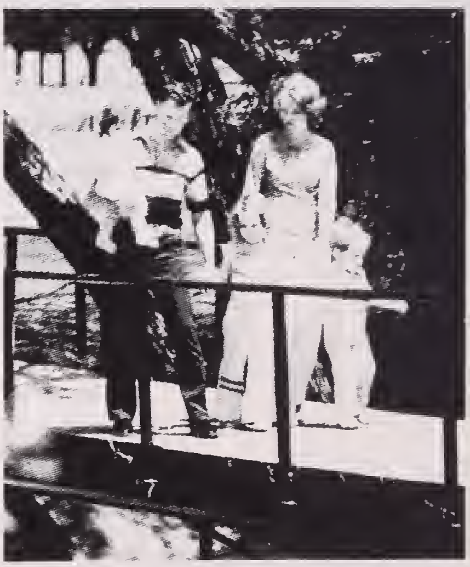

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See following page for brief summary of prescribing information.

SORBITRATE
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%) An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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WashingtoNotes

(Continued from page 18A)

necessarily angered hospitals and physicians in their area.

The federal PRO management team will also be keeping tabs on progress PROs make toward meeting the stiff new admission-reduction and quality-enhancing goals the winning organizations set for themselves. Staff from HHS' Inspector General's Office also will be looking at the PROs as part of their overall task of monitoring Medicare's prospective pricing system. Super PRO will play a critical role in the monitoring process.

Bids on the Super PRO contract were due by November 30 and several organizations, including the American Medical Association, were bidding.

The winner will be scrutinizing the PROs medical review decisions to assure that they are "consistent" and "appropriate" and that they are made by "appropriate staff or representatives."

In addition to selection of the Super PRO, the new peer review groups are still awaiting publication of four sets of final PRO regulations, including a controversial proposal governing confidentiality of data collected by the PROs. Proposed confidentiality regulations that made public data on identifiable individual hospitals were criticized by hospitals and physicians as too loose. Representatives of business, labor and the elderly want to eliminate the proposal rules' protection of individually identifiable physician data.

Other regulations still to come will govern the conduct of review, sanctions and appeals.

A recent regulatory agenda published in the Federal Register anticipates publication of a final regulation by the end of December. Another set of regulations governing conditions under which Medicare will pay for certain services later found to have been unnecessary is still being drafted.

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(Continued on page 62)

THE NEBRASKA MEDICAL JOURNAL

Regular Caffeine Consumption: Effects on Resting Cardiovascular Function and Cardiovascular Changes Induced by Mental Challenge

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University of Nebraska Medical Center

JAMES C. BUELL, M.D.
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CAFFEINE administration has been shown to have a number of effects on the cardiovascular system. Dobmeyer, et al.[1] provided 200 ml of coffee to five patients with rhythm disorders and intravenously administered caffeine to fourteen other patients, seven of whom had evidence of rhythm disorders. The level of caffeine administered intravenously approximated the amount found in two cups of brewed coffee. They found that both oral ingestion of coffee and intravenous administration of caffeine had electrophysiologic effects in patients and controls. Supraventricular tachycardia developed in both patients and controls, and while ventricular tachycardia was not found in any of the controls, it did develop in two patients after caffeine infusion.

In addition to the electrophysiologic effects, a number of investigators have found that caffeine produced elevations in plasma epinephrine and norepinephrine levels which are paralleled by increases in blood pressure and heart rate.[2,3] Freestone and Ramsay found that when mild hypertensives who habitually drink coffee then abstained from such use for twelve hours, their systolic and diastolic blood pressure decreased significantly. Subsequent administration of coffee (caffeine content of 200 mg) resulted in a significant increase in blood pressure that was maintained for one to two hours.[4]

These effects of caffeine parallel those found in studies of the physiologic effects of stress on the cardiovascular system. It has been hypothesized that caffeine may even intensify these cardiovascular responses to stress. Henry and Stephens provide some support for this hypothesis in their finding that the substitution of coffee for drinking water produced greatly increased rates of disease and mortality in mice living in large community cages where stressful, competitive interaction typically led to cardiovascular and renal pathology.[5] The consumption of caffeine led to increases in blood pressure, adrenal weight, plasma renin and corticosterone above that found in mice exposed to the same competitive social stimulation without the consumption of caffeine.

Lane examined the cardiovascular effects of moderate doses of caffeine, equivalent to two or three cups of coffee, during periods of rest and psychologic stress.[6] Using a sample of males aged 18 to 20, who reported rare consumption of coffee, tea or caffeinated soft drinks, Lane found that resting blood pressure was significantly elevated in subjects who consumed caffeine and then were monitored 45 minutes later. This study also noted an additive effect for caffeine consumption and psychologic stress — both systolic and diastolic blood pressure showed significantly more increase during psychologic stress for subjects who consumed caffeine as opposed to a placebo. No comparable effect was found for heart rate.

---

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There is some evidence that regular use of coffee can be associated with increased levels of serum cholesterol. Thelle, et al.[7] found that increased coffee consumption among the 14,667 participants in the Thormso, Norway, heart study was significantly related to increased total cholesterol levels. As is well known, elevated cholesterol levels can contribute to the risk of developing coronary heart disease. Acute administration of caffeine to subjects who do not regularly consume caffeinated products can also increase blood pressure at rest and during psychologic stress, and increased blood pressure is another risk factor for CHD development. However, it is not clear if regular caffeine use leads to chronically elevated BP (a risk factor), or if this is only an acute phenomenon.

The purpose of the present study is to explore the association between *regular* use of caffeinated drinks, resting blood pressure and hemodynamics, and cardiovascular reactions to moderate mental challenge. We are interested in exploring whether a history of regular use of caffeinated beverages has the same additive effect on cardiovascular functioning during mental challenge as studies using acute administration of caffeine have shown, and furthermore whether regular caffeine use might lead to chronically elevated blood pressure, a known risk factor for CHD.

METHODS

Subjects

Subjects were 60 healthy male managers and engineers from a local production plant (AT & T Information Systems - Omaha Works), whose average age was 45.05 ± 8.2 years. All volunteered as part of a cooperative program between AT & T and the Department of Preventive and Stress Medicine in which employees served as research subjects in exchange for information regarding their health status. Upon volunteering, subjects were screened by the medical director at AT & T and his staff, and later an additional screening was performed by staff of the Department of Preventive and Stress Medicine to ensure that all participants were healthy and not taking medication.

Procedure

Each subject reported to the Department of Preventive and Stress Medicine at 7:30 a.m. on the assigned day of testing. They had been asked to fast for twelve hours prior to their appointment and to abstain from use of caffeinated beverages for this same period of time. Subjects signed an informed consent statement which explained the nature of the study and the procedure to be used. A certified physician's assistant then conducted a brief history and physical during which a cannula was inserted into a left antecubital vein, a stopcock attached, and the apparatus taped into place. During the history and physical the subject was asked to estimate the amount of caffeinated beverages (coffee, tea, soft drinks, etc.) he consumed each day. Consumption was measured in cups or glasses per day. Subjects also reported on their smoking patterns, both in terms of how long they had been smoking (in years) and the amount they smoked per day (in packs). Additionally, all subjects were asked about their weekly alcohol consumption (in drinks per week).

The subject was then escorted to the subject room, where all electrodes and transducers were attached by a technician. The subject was seated in a comfortable recliner, the lights were dimmed and the subject was asked to relax for ten minutes. Blood pressures were taken five, eight and nine minutes after the rest period began. Following completion of the baseline, the technician reentered and removed 20 cc of blood via the stopcock. This was placed in an iced (0°C) test tube and transported to a local laboratory for standard SMAC-24 analysis the same day.

The subject then performed a video game task. Instructions told the subject to increase his score each time he played and that "persons with normal psychomotor skills can usually do this." The subject was allowed to play the video game for six minutes, while four blood pressure readings were taken and heart rate and cardiac function were monitored. A rest period followed this task.

The subject was then asked to perform a reaction-time task in which he observed a panel of ten lights (two each of five colors) which flashed periodically. The subject responded by pushing a button matching the color of the flashed light as quickly as possible. Blocks of 50 trials were conducted until the subject was unable to succeed on 25 or more trials. The subject then worked at this "breakdown" speed for one minute during which one blood pressure reading was taken and heart rate and cardiac functon were monitored continuously. A five minute recovery period followed completion of the reaction-time task.

The last task performed by the subject was the cold-pressor test. Subjects were asked to immerse their right hand in a bucket of ice water (2°C) and hold it there for 90 seconds. Blood pressures were taken after 15 and 60 seconds of immersion. Heart rate and cardiac function were monitored continuously throughout the 90-second period, and a five-minute relaxation period followed completion of the task. Recording devices were then disconnected, the connection sites were cleaned and the subject was debriefed.

All instructions were standardized and presented via videotape and the subject and technician could communicate via an intercom. Blood pressures were measured by an automatic ultrasonic device (Infrasonde Model D4000-Puritan Bennett, Inc.), and heart rate was measured using standard electrocardiographic procedures. Cardiac functioning was determined through use of impedance cardiographic procedures. A complete description of the procedures used in this study and data concerning their reliability and validity are presented in a recently completed study.[8]

Results

As part of the history and physical, subjects were asked to estimate the number of cups or glasses of caffeinated beverages they consumed per day. Subjects reported a normally distributed pattern of caffeine consumption with a maximum of 11 cups or glasses of caffeinated beverages per day and a mean of 3.82 ± 0.37. Eight of the 60 subjects reported no caffeine consumption.

The association between regular caffeine consumption and resting cardiovascular measures was analyzed using Pearson's Product Moment Correlations. Table 1 presents the correlations between reported caffeine consumption and systolic blood pressure (SBP), diastolic blood pressure (DBP), mean blood pressure (MBP), total systemic resistance (TSR), vascular rigidity index (VRI), stroke volume index (SVI), heart rate (HR), cardiac index (CI), heather index (HI: a measure of ventricular contractility), mean systolic ejection rate (MSER) and left ventricular ejection time (LVET) measured during the baseline period. The last column of Table 1 presents the correlations between caffeine consumption and these measures of cardiac functioning only for those subjects who reported some consumption of caffeinated beverages.

Table 1

Correlations between Reported Caffeine Consumption and Cardiovascular Functions at Rest

Measure	r	r for caffeine drinkers only
SBP	0.10	0.13
DBP	0.23*	0.31*
MBP	0.21	0.28*
TSR	0.19	0.23
VRI	0.11	0.05
SVI	−0.12	−0.23
HR	0.09	0.03
CI	−0.14	−0.10
HI	−0.008	0.07
MSER	−0.14	−0.10
LVET	0.07	0.12

*p < 0.05

Table 1 indicates that there is a significant positive relationship between caffeine consumption and resting diastolic blood pressure ($r = 0.23$, $p < 0.05$). If just those subjects who reported caffeine consumption are considered, there is not only a significant positive relationship for diastolic blood pressure ($r = 0.31$, $p < 0.05$), but there is also a significant positive relationship between caffeine consumption and mean blood pressure at rest ($r = 0.28$, $p < 0.05$). While the relationship for total systemic resistance ($r = 0.23$, $p = 0.055$) and stoke volume index ($r = -0.23$, $p = 0.053$) approaches significance for those subjects who reported caffeine consumption, neither of these measures nor any of the others is significantly related to reported caffeine consumption.

Table 2 presents the correlation coefficients for each measure of cardiovascular functioning during each stress task. As with Table 1, Pearson's Product-Moment Coefficients were computed for the entire sample and then for a sample excluding subjects who reported no caffeine consumption.

The correlations reported in Table 2 indicate the relationship between caffeine intake and the absolute values of the cardiovascular measures obtained during each stress task. In no case was there a significant association between reported caffeine intake and cardiovascular functioning. In fact, the relationship between caffeine intake and diastolic blood pressure, which was significant and positive at baseline for both the total sample and the caffeine drinkers, was not significant for DBP under mental or physical challenge. Likewise, the positive relationship at baseline between mean blood pressure and reported caffeine consumption for caffeine drinkers was not found under mental or physical challenge.

In earlier reports, much of the association between caffeine and risk for CHD was explained in terms of the association between caffeine consumption and smoking behavior. Table 3 presents the correlations found between reported caffeine intake, the number of years subjects reported smoking, the amount subjects reported smoking and their reported alcohol consumption (in drinks per week).

No significant association was found between reported caffeine consumption and smoking. Neither the measures for amount of smoking nor the years of smoking were significantly associated with caffeine consumption. Reported alcohol consumption did show a significant positive relationship with reported caffeine consumption ($r = 0.43$, $p < 0.01$). When those subjects who reported no caffeine intake were eliminated from the analysis, the strength of the relationship between caffeine and alcohol consumption decrease ($r = 0.31$, $p < 0.05$). However, this relationship was still significant.

Table 2

Correlations Between Reported Caffeine Consumption and Cardiovascular Functions During Mental and Physical Challenge.

Measure	Video Game		Reaction-Time		Cold Pressor	
	Total r	r for caffeine drinkers only	Total r	r for caffeine drinkers only	Total r	r for caffeine drinkers only
SBP	0.09	0.04	0.15	0.06	−0.03	−0.07
DBP	0.18	0.16	0.18	0.11	0.07	0.001
MBP	0.15	0.13	0.18	0.10	0.04	−0.04
TSR	0.12	0.16	0.13	0.20	0.13	0.17
VRI	0.03	−0.06	0.19	0.13	−0.03	−0.06
SVI	−0.08	−0.02	−0.03	−0.16	−0.04	−0.02
HR	0.09	0.03	−0.03	−0.12	−0.04	−0.13
CI	−0.12	−0.12	−0.03	−0.06	−0.20	−0.14
HI	0.08	0.14	0.02	0.10	0.08	0.16
MSER	−0.08	−0.06	−0.13	−0.12	−0.06	−0.04
LVET	0.04	0.15	0.02	0.13	0.12	0.10

Table 3

Correlations Between Reported Caffeine Consumption and Other Behavioral Risk Factors.

	Total r	r for Caffeine Drinkers Alone
Smoking Time	0.14	0.12
Amount Smoked	0.18	0.12
Alcohol Consumption	0.43**	0.31*

*p < 0.05 **p < 0.01

Discussion

At first glance, this study would seem to conflict with the results found by Lane.[6] While Lane found that acute administration of caffeine resulted in a significantly more exaggerated blood pressure response to mental challenge, our results indicate no relationship between degree of blood pressure response during stress and chronic caffeine consumption. Two differences in these studies are important. Lane's subjects did not regularly use caffeinated beverages, and he administered caffeine before the testing procedure so that the drug would have its cardiovascular effect during the testing period. The present study was interested in whether *regular* caffeine use would lead to a systematic change in cardiovascular response, so no caffeine was administered before the test. In fact, it was purposely excluded from the subject's diets at least ten hours prior to testing. The lack of an association between reported caffeine intake and stress-induced cardiovascular change indicates that a regular pattern of caffeine use has no systematic effect on the magnitude of cardiovascular stress reactions. That is, there appears to be no additive effect of regular caffeine use.

The present study does appear to confirm and extend the results of Lane, Robertson, et al.[2], and Levi[3] with respect to baseline blood pressure. These studies all found that administration of caffeine raised resting blood pressure. The study described here further indicates that as the amount of regularly consumed caffeine increases, so does resting diastolic and mean blood pressure. Apparently, a regular pattern of caffeinated beverages consumption has the effect of resetting baseline levels. This is in spite of the exclusion of caffeine from the subjects' diets twelve hours before testing, which, according to Freestone and Ramsay,[4] should have resulted in a decrease in systolic and diastolic blood pressure.

The present study may implicate regular caffeine use in the etiology of coronary heart disease in that caffeine consumption appears to be related to elevated diastolic blood pressure and thus, possibly, essential hypertension, which has received consensual validation as a risk factor for coronary heart disease.[9] However, the evidence for an independent association of coffee consumption with cardiovascular disease has been equivocal. Dawber et al.[10], Klatsky et al.[11], and Hennekens et al.[12] found no evidence for an association between coffee consumption habits and development of cardiovascular difficulties. Other studies, however, have found associations between reported coffee consumption and the incidence of cardiovascular pathology.[13-15] In some cases the positive associations have been explained in terms of the relationship between high levels of coffee consumption and cigarette-smoking habits.[10,11] That association was not found in this study. In fact, caffeine consumption was neither associated with the amount of cigarette smoking, nor the number of years of cigarette smoking.

The results of this study indicate that as regular use of caffeinated beverages increases the resting levels of diastolic blood pressure and mean blood pressure increase as well. There is also an indication that regular caffeine use may be associated with increased systemic resistance and decreased stroke volume. These relationships approached significance ($ps = 0.055$ and 0.053 respectively). While this is not direct evidence for a caffeine effect on the etiology of coronary heart disease, or any other chronic disorder, it does indicate that there are cardiovascular changes associated with regular use of caffeine. Regular caffeine consumption does not, however, appear to be related to differing cardiovascular reactions to mental challenge.

These findings must be tempered by the correlational nature of the present investigation. The use of correlational statistics indicates only that there is an association between higher levels of reported caffeine intake and elevated levels of DBP and MBP. They do not provide any information regarding how much caffeine leads to what degree of increase, or if these increases are necessarily pathological. Additionally, correlation does not imply a causal association between any two variables.

A second limitation is that caffeine consumption was measured by a one-time retrospective self-report. That is, subjects were asked during their history and physical examination to estimate the amount of caffeinated beverages they consumed on a normal day. This method of data collection can be somewhat inaccurate in terms of absolute levels of beverage consumption. There was also a significant positive relationship between caffeine and alcohol consumption. It is possible that some of the changes found in this study may be attributed to alcohol rather than caffeine consumption.

Summary

The literature in recent years provides contradictory evidence concerning the involvement of caffeine consumption in the development of cardiovascular difficulties. This study looked at the correlations between regular patterns of caffeine consumption and cardiac functioning. The results indicate a significant association between higher levels of caffeine consumption and elevated diastolic and mean blood pressure at rest. There was no evidence of an association between caffeine consumption and increased cardiovascular reactivity during mental or physical challenge. Additionally, this study found no association between caffeine consumption and cigarette smoking behavior.

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Problems in Diagnosis and Treatment of Infantile Hypertrophic Pyloric Stenosis

Presented at the American College of Surgeons Meeting Nebraska Medical Association Meeting, April 1984

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INFANTILE hypertrophic pyloric stenosis (HPS) is a relatively common condition seen in pediatric surgery. It affects healthy babies and is a frequent indication for abdominal operations in infancy. Diagnosis is made using clinical history, physical examination, radiographic contrast studies and, occasionally, ultrasound. Since earlier diagnosis is being made, traditional problems of severe electrolyte imbalance, dehydration, and acid-base disturbances are less common. When congenital anomalies and individual problems occur in conjunction with HPS, difficulties can arise in clinical management of these infants. Reports have described gastro-intestinal anomalies and complications occurring with HPS.[1-3] We reviewed our experience over an eight year period to identify significant problems and complications that delayed diagnosis and treatment of infants with HPS.

Materials and Methods

One hundred sixty-four infants with HPS were treated at Children's Memorial Hospital and University Hospital between January 1975 and December 1983.

The patients charts were reviewed retrospectively to determine abdominal examination findings, radiographic contrast findings, operative conditions and associated conditions altering the diagnosis and clinical management. All infants underwent several physical examinations prior to general anesthesia. If abdominal findings were inconsistent, those noted by the senior surgeon were recorded.

Results

The study group included 124 males and 40 females aged 1 to 18 weeks (mean 5.2 wk). Ninety percent of patients were 8 weeks of age or younger. There was no seasonal variation. Mean hospital stay was 5.9 days and 40 percent of patients were hospitalized 4 days or less.

Physical examination identified a pyloric tumor in 90 patients (55%); peristaltic waves were found in 39 patients (24%). Both abdominal findings were present in 29 patients (18%). Sixty-two patients (38%) had neither physical finding recorded.

Radiographic contrast studies were performed in 162 patients. No indication could be obtained from the record why the study was omitted in two patients. A pyloric tumor was palpated in both cases.

Operative complications are shown in Table I. All duodenal perforations were identified at operation. The mucosal defects were closed with interrupted suture and buttressed with a pedicle of omentun. Only two patients with duodenal perforations developed wound infections. In one patient there was documentation of wound dehisence secondary to wound infection. There was a single death unrelated to HPS.

Eighteen of 164 patients has associated problems that delayed diagnosis and treatment of HPS. There were 10 male and 8 female patients with mean age of 7.6 weeks.

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Mean hospital stay was 19 days. Two duodenal perforations and one wound dehisence occurred in this group. Table II shows the problems identified in this group of patients.

Table I

Operative Complications

Duodenal perforations	15	9.5%
Wound infection	13	7.9%
Dehisence, eviceration	3	1.8%
Urinary tract infection (E.coli)	1	

Table II
Problems Delaying Diagnosis and Treatment of HPS

Congenital heart disease	3
Metabolic disorder	3
Infection	2
Previous operation	4
Nonoperative treatment	2
Hyperbulirubinemia	2
Inadequate pyloromyotomy	1
Error in diagnosis	1
Respiratory Arrest	1
Apnea	1

Congenital heart disease occurred in three patients. One patient underwent emergency aortic commissurotomy for critical aortic stenosis during the first week of life; postoperatively he developed vomiting and intermittent diarrhea which failed to resolve with medical management. Upper gastro-intestinal contrast studies showed delayed gastric emptying with possible duodenal scarring. Gastroscopy identified no intraluminal pyloric obstruction. Celiotomy revealed HPS with malrotation. Two patients underwent cardiac catheterization prior to pyloromyotomy. One patient presented with vomiting and congestive heart failure. A ventricular septal defect was identified. Vomiting persisted after resolution of heart failure. Radiographic contrast studies showed HPS. A third patient presented with acrocyanosis and post prandial vomiting. Evaluation revealed pulmonic stenosis with an atrial septal defect and HPS. Abdominal examination was normal in all three patients.

Only three patients had problems secondary to fluid and electrolyte disturbances. Hyponatremia leading to seizures occurred in one patient. This patient underwent hypodermoclysis at another hospital. In a second patient lethargy secondary to hypochloremic alkalosis lead to sepsis evaluation. The third patient required peripheral nutritional support one week preoperatively because of malnutrition and failure to thrive. This patient was born four weeks premature and weight 2.32 kg at seven weeks of age.

Problems related to infection were present in two patients. Broncho-pneumonia delayed operation in one patient and **Klebsiella pneumonia** pharangitis was treated preoperatively in another patient.

Four patients had operations prior to pyloromytomy. A gastrostomy and repair of a tracheo-esophageal fistula was performed 6 weeks before pyloromyotomy in one patient. Another patient with multiple neurological anomalies and inability to feed underwent gastrostomy and placement of a ventriculo-peritoneal shunt before HPS was diagnosed. A third patient with Trisomy 18 required a feeding gastrostomy at the time of pyloromyotomy. Aortic valve commissurotomy and omphalocele repair was performed four weeks prior to pyloromyotomy in another patient.

Two patients were managed nonoperatively. In a 12 week infant upper gastrointestinal contrast studies showed an elongated pyloric channel and ultrasound showed a thickened pyloric muscle, both consistent with HPS. However, because of the patient's continued weight gain and age, pyloromyotomy was delayed. At 14 months the patient remained in the 50th percentile for weight. A second patient with hyperthyroidism and radiographic studies consistent with HPS was treated with atropine and thickened feedings. Medical management was implemented because of hyperthyroidism. At one year of age the pylorospasm had resolved and medical management was discontinued.

One patient underwent pyloromyotomy at another hospital. However, vomiting and weight loss continued three weeks postoperatively. Gastroscopy and upper gastrointestinal contrast studies showed gastric outlet obstruction. Reoperation revealed inadequate gastric extension of the pyloromyotomy. A second Ramstedt pyloromyotomy was performed 180° opposite the original myotomy.

An error in diagnosis occurred in one patient with a pyloric tumor not confirmed at operation. Two patients had hyperbilirubinemia that resolved with pyloromyotomy. One patient had apnea secondary to gastroesophageal reflux and chalasia. Another patient developed respiratory arrest probably secondary to preoperative medications. Both patients underwent neurological evaluations prior to pyloromyotomy.

Discussion

HPS is one of the most common abdominal conditions requiring operation in babies. It affects males more often than females in a ratio of 4:1.[4] The male to female ratio was 3:1 in our patient group. Congenital anomalies, primarily of the gastrointestinal system, have been estimated to occur in 6 to 12 percent of patients with HPS.[1, 2] Physical findings seen with HPS are a palpable pyloric tumor and visible peristaltic waves. Spicer reports a pyloric tumor can be palpated in 40 to 100 percent of patients in published series[5] and is diagnostic of HPS. 55 percent of our patients demonstrated a pyloric tumor. The percentage of tumors palpated varies with the thoroughness, patience and experience of the examiner.

HPS treated by pyloromyotomy is associated with low morbidity and mortality. The mortality rate is 0.3-0.6 percent.[4] Ahmed reports 4 deaths in 329 cases of HPS.[1] Three of the infants had major associated anomalies including esophageal atresia, Hirschsprung's disease and congenital heart disease. Unrecognized duodenal or gastric perforations leading to peritonitis is usually fatal.[2] Mucosal perforations occur in 1.5 to 11.3 percent of cases[2, 6] and are related to the experience of the surgeon. If the defect is identified and repaired, these infants can be expected to have an uneventful recovery. Gastric decompression is necessary for 24 hours and oral feedings should be delayed for 48 hours. Mean hospital stay was 6.5 days in our patients with duodenal perforations.

Inadequate pyloromyotomy is rare and reoperation should be postponed at least 14 days, as nearly all vomiting will resolve during this time. Upper gastrointestinal series are difficult to interpret when performed within 3 months of operation.

Medical treatment of HPS is rarely indicated nowadays. Corner reports 115 of 117 cases of HPS cured with medical management.[8] However, hospital stay is prolonged and considerable demands are placed on nursing staff and parents. Pyloromyotomy is the treatment of choice except on the rare occasion where the length of history and the good condition of the infant indicates the disease is resolving.

Abdominal examination may be difficult because of scars from previous operations or unusual presentations making palpation of the pyloric tumor diffcult or unreliable. Barium contrast studies and ultrasound can assist in diagnosing HPS in complicated cases. Ball, et al, has recently recommended ultrasound as the initial imaging procedure for diagnosis of HPS.[7]

Diagnosis of HPS in the uncomplicated case is straight forward and is based on projectile vomiting, visible peristaltic waves and a palpable pyloric tumor. When HPS occurs concurrently with another problem, clinical presentation may be atypical. Vomiting seen with congenital heart disease, tracheoesophageal fistula, metabolic disorders, infections or in the postoperative period may or may not be caused by HPS. Vomiting with congenital heart disease may be interpreted as a sign of congestive heart failure or digoxin toxicity. The classic symptoms and findings of HPS may not be present after tracheoesophageal fistula repair and gastrostomy. Andrassy and Mahoun report an increased incidence of HPS with esophageal anomalies.[4] This may be related to the decompressive gastrostomy. It is postulated continuous gastric decompression decreases intraluminal pressure to levels insufficient to keep the pyloric channel open leading to pyloric stenosis.[1, 2] This may also account for recurrent stenosis after pyloromyotomy in some cases.

This group of patients demonstrates several problems encountered in infants with HPS. However, with appropriate diagnostic intervention, preoperative preparation and postoperative care, these problems should not alter successful treatment of HPS; these infants can be expected to have a similar outcome as infants with uncomplicated HPS.

Summary

Infantile hypertrophic pyloric stenosis (HPS) is a relatively common condition. Since earlier diagnosis is being made, traditional problems of severe electrolyte imbalance and dehydration are less common. Difficulties arise in clinical management of these infants when other problems occur in conjunction with HPS. We reviewed the records of 164 patients over an eight year period to identify significant problems that delayed the diagnosis and treatment of infants with HPS.

There were 124 males and 40 females. Age ranged from one week to eighteen weeks with 73% of patients being less than six weeks old. 75% of patients were hospitalized six days or less. Physical examination identified a pyloric tumor in 90 patients, peristaltic waves in 39 patients and both physical findings were present in 29 patients. Radiographic contrast studies were obtained in 162 patients. Wound infection and duodenal perforation were the most common complications related to operation. Eighteen patients were identified with significant problems that delayed diagnosis and treatment of HPS. There was a single death that was unrelated to HPS.

This group of patients demonstrates several problems encountered in infants with HPS. However, with appropriate management these problems should not alter successful treatment of HPS; these infants can be expected to have similar low mortality as infants with uncomplicated HPS.

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Abdominal Surgery in the Elderly Patient

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THE people of Nebraska have one of the longest natural life expectancies in the continental United States. Thirteen percent of Nebraskans are over the age of 65 as compared with 11% in the United States as a whole. In many counties in Nebraska the percentage of individuals over age 65 approaches 30%. Thus, surgeons in Nebraska are often called on to treat older patients.

The decision to operate on an elderly patient is difficult and requires the consideration of not only medical, but also ethical, social and financial factors. There have been several reports that elective operations on elderly patients can be performed with acceptable morbidity and mortality.[1,2,3,4] Many of the complications that occur are due to pre-existing conditions.

We reviewed our experience at the University Hospital with 131 patients over the age of 70 who underwent major abdominal operations in the past 4 years to assess the morbidity and mortality and the postoperative quality of life of these patients.

Materials and Methods

Records of 131 patients over the age of 70 who underwent celiotomy at the University Hospital from 1980 to 1984 were reviewed. The ages ranged from 70 to 96 with an average age of 76 years. The records were reviewed to determine the operation performed, the urgency of the operation, postoperative morbidity and mortality within 30 days of the operation, and patient outcome. If more than one complication occurred, only the most significant was considered.

The presence of pre-existing conditions was evaluated by reviewing the results of electrocardiograms, pulmonary function tests, chest x-rays and the clinical history. The need for intensive care and ventilatory support was also determined. The patients' disposition from the hospital was noted as indication of post-operative quality of life.

Complications and deaths were considered to be related to pre-existing conditions if the organ system involved was documented as being diseased preoperatively, e.g. cardiac arrhythmias in a patient under treatment for known cardiac disease. Other complications were clearly related to the operation itself, e.g. retained common duct stone.

Results

The operative procedures performed on 131 patients are shown in Table 1. Approximately ⅓ of patients underwent colon operations, ⅓ underwent operations on the biliary system and the remainder had vascular, gastric or other procedures. The miscellaneous category included resection for mesenteric infarction, intestinal obstruction, and appendectomy. Twenty-two percent of the operations were emergent.

Overall twenty five patients (19%) died postoperatively (Table 2). However, 17 deaths occurred in the 29 patients undergoing emergency procedures, for a mortality rate of 59%, compared to 8 deaths among the 102 patients undergoing elective operations for a mortality rate of 8%. Non-fatal postoperative complications occurred in 27 (21%) patients. Again, the complication rate was higher in emergent than non-emergent operations (33% vs 24%).

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Postoperative morbidity and mortality were related to technical errors, pre-existing conditions, and the disease being treated (Table 3). Fourteen patients had complications or died due to technical errors during the operation. In 23 patients complications or death were related to pre-existing conditions. Eight of these 23 were related to the disease being treated. The cause of complication and death in twenty (38%) of the patients was infection, most commonly pneumonia.

Fourteen patients had evidence of a previous myocardial infarction by preoperative electrocardiogram. However, none of these patients had cardiovascular complications. In fact, only one patient sustained a myocardial infarction postoperatively.

TABLE 1

Operations Performed

	EMERGENT	NONEMERGENT	TOTAL
COLON	5	36	41
BILIARY	7	32	39
GASTROESOPHAGEAL	6	13	19
VASCULAR	2	8	10
PANCREAS	1	6	7
MISCELLANEOUS	8	7	15
TOTAL	29	102	131

TABLE 2

Mortality Related to Urgency and Type of Operation

	EMERGENT OPERATION	NONEMERGENT OPERATION	TOTAL
COLON	3 (60%)	2 (6%)	5 (12%)
BILIARY	2 (29%)	0 (0%)	2 (5%)
GASTROESOPHAGEAL	3 (50%)	2 (15%)	5 (26%)
VASCULAR	2 (66%)	1 (13%)	3 (30%)
PANCREAS	1 (100%)	1 (17%)	2 (29%)
MISCELLANEOUS	6 (75%)	2 (29%)	8 (53%)
TOTAL DEATHS	17 (59%)	8 (8%)	25 (19%)

Twenty-two patients had an albumin of less than 3.0 gm percent and 68% of these patients had postoperative complications. Sixty-two patients had an albumin greater than 3.0 gm percent. Only 27% of these patients had complications.

Eighty-four of the 131 patients were admitted to the intensive care unit postoperatively but the majority were there only one or two days for observation. Forty-five patients required ventilatory assistance for greater than 24 hours postoperatively, but only one required ventilatory support for more than a week. Twelve of these patients had chronic obstructive pulmonary disease and 26 of the 45 patients died. Nine of the 106 patients who left the hospital went to a nursing home environment for the first time.

Discussion

With the increasing number of elderly people in the United States, a surgeon is frequently asked to perform a major operation on these patients. Important medical considerations are the postoperative morbidity and mortality to be anticipated and the risk that the patient's disease may later present in a more complicated state or as an emergency. There are also economic considerations such as the expense and availability of resources and ethical considerations such as the patient's quality of life following operation.

There seems to be little doubt that patients greater than 70 years of age have a higher morbidity and mortality than younger patients undergoing the same operation. In the review of our experience with cholecystectomy, elderly patients had a 2-3 fold increase in mortality compared to younger patients undergoing the same operative procedure.[5]

Why this is so has several explanations. The more frequent need for an emergent operation, the presence of underlying disease, the patient's presentations with a more advanced disease and the effects of age itself all play a role.

There have been several reports of the high morbidity and mortality associated with emergency operations in the elderly patient.[1,2,3,6,7] In the present study, the mortality of the emergency operations is more than 7 times that of elective operations. The 8% mortality in the present study for elective operations is similar to that reported in other studies.[1,2,3,6,7]

Approximately 80% of elderly patients will have other health problems that increase their risk of operations.[1,2] These include ischemic heart disease, pulmonary disease, and diabetes mellitus.[1,2,3,4] Whether these associated problems are the major cause of the increased morbidity and mortality following operations in the elderly patient is not clear.[1,3,5] We found that 23 (44%) of the complications and deaths inthe postoperative period were related to preexisting conditions but 8 of these were due to the disease being treated. Nineteen of 52 deaths or complications were due to the operations, or conditions not present prior to the operation.

Elderly patients frequently present with diseases in a more advanced state which increases the morbidity and mortality.[1] For example, one author found the elderly patients or their physicians would postpone elective cholecystectomy so that by the time these patients finally came to operation, they were more likely to have choledocholithiasis and cholecystitis.[7,8] We found previously that choledocholithiasis was present in 25% of patients greater than 70 years of age compared to 8.5% in younger patients and acute cholecystitis occurred twice as often in elderly patients (23 vs 12%).[5] The mortality following cholecystectomy with common bile duct exploration in our study was higher (16%) than that for cholecystectomy alone (0%).

Twenty (38%) complications or deaths were due to infections. These infections are likely due to a combination of local and systemic factors. With age there is a decrease in both T-cell and B-cell function. Fewer antibodies

TABLE 3

Causes of Postoperative Morbidity and Mortality

	Complications	Death	Total	Due to Underlying Disease
PULMONARY				
Pneumonia	4	2	6	3
Pulm Embolism	0	1	1	0
Prolonged Vent	1	0	1	1
ARDS	0	1	1	1
Total	5	4	9	5
SEPSIS OR ABSCESS	4	7	11	8
CARDIOVASCULAR				
Arrhythmias	1	0	1	0
MI	0	1	1	0
CVA	1	0	1	1
CHF	1	0	1	1
Shock	0	3	3	3
Mesenteric Ischemia	0	3	3	3
Total	3	7	10	8
RENAL				
UTI	3	0	3	0
Renal Failure	1	1	2	0
Dialysis	0	1	1	0
Total	4	2	6	0
SECONDARY TO OPERATION				
Wound dehiscence	1	0	1	0
Retained stone	1	0	1	0
Anastomotic leak	2	2	4	0
Diabetes	1	0	1	0
Failed operation	1	0	1	0
Intestinal obstruction	1	0	1	0
Transected ureter	1	0	1	0
Splenectomy	1	0	1	0
Liver injury	1	0	1	0
Bleeding	0	1	1	0
Pancreatitis	1	0	1	0
Total	11	3	14	0
CARCINOMATOSIS	0	2	2	2
TOTAL	27	25	52	23

are produced and there is a decrease in T-helper compared to T-suppressor cell function.[9,10,11]

Pneumonia was the most common localized infection in this series. With age, the rib cage become less mobile and the patients become more dependent on abdominal breathing.[12] Bed rest and abdominal surgery impair abdominal breathing and predispose to pneumonia. We feel that early ambulation and standing patients for deep breathing would allow full lung expansion and diminish the incidence of post operative pneumonia.

There is an increased risk of infection in malnourished patients.[9] This was confirmed in our study. The elderly often have poor dietary habits, deficient in vitamins and protein. It is important to be aware of malnutrition in elderly patients and to improve the patient's nutritional status preoperatively, and to continue nutritional support postoperatively.

Surgical therapy in the elderly patient raises ethical as well as social issues. The quality of life after an operation is a very important consideration for the elderly. Many elderly patients would choose not to have an operation if there was an appreciable risk of mental or physical impairment postoperatively.[13] This is based not only on their concerns about the quality of life, but also about the appropriate use of limited medical resources. Only nine of the 106 patients in this series who left the hospital had such significant physical and mental impairment that they were unable to return to their previous living arrangement. This suggests that the quality of life for the 91% who return home is quite good.

Summary

Major abominal operations in the elderly are associated with a significant morbidity and mortality. This higher morbidity and mortality is related to pre-existent disease, the frequent need for emergency operations and the changes of normal aging. Patients are at particular risk for infectious complications. These complications can be minimized by: early operation, early standing and ambulation postoperatively, efficient recognition and vigorous treatment of infection, plus nutritional support.

Timely surgical intervention is encouraged by the fact that quality of life is reasonably good following surgical intervention, and that emergent operations have a 7 times higher mortality rate compared to elective operations.

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Myospherulosis

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MYOSPHERULOSIS, an inflammatory disease of soft tissues and bone, has recently been described in the nose and paranasal sinus. Although previously reported in the ENT literature,[1,2] the disorder is still unfamiliar to most physicians including many otolaryngologists. The most important aspect of the disease is that it is an iatrogenic disorder caused by petroleum based packs used in nasal surgery.

Myospherulosis was first reported in 1969 by McClatchie,[3] et al, in a series of African patients with soft tissue masses of the extremities. In 1977, Kyriakos reported sixteen cases involving the nose and paranasal sinuses in which he suspected Petroleum-based packing to the causative factor.[4]

Several investigators[2,4-6,9] have now confirmed that petroleum, acting as a foreign body, reacts with erythrocytes to produce the disease. Causative agents include petroleum, lanolin, and endogenous lipids. When maintained in prolonged contact with extravasated erythrocytes, these hydrocarbons cause the red blood cells to clump together and form spheres. The spheres, suspended in the hydrocarbon material, are contained within multiple cysts. An inflammatory reaction then occurs which causes pain, the primary symptom of the disease.

Case Study

CK, a thirty-seven-year-old white male, was seen in February, 1982, complaining of facial pain. Past medical history revealed a fall in 1980 that caused a nasal injury with coral sand getting into the nasal cavity. Bilateral maxillary sinusitis developed along with nasal airway obstruction. A nasal septoplasty with bilateral nasal antral windows was performed in December, 1980. Facial pain and swelling continued. The patient subsequently had a bilateral Caldwell-Luc (maxillary sinuostomy by transoral approach), performed twice, once in May, 1981, with the second in June, 1981. The second operation was performed for pain. In November, 1981, a third bilateral Caldwell-Luc was performed with a bilateral ethmoidectomy. On each occasion, the nose and paranasal area was packed with gauze containing Aureomycin, a petroleum based material. In spite of surgery and multiple courses of antibiotics, the mid-facial pain continued.

Initial physical exam revealed a thirty-seven-year-old male with mid-facial pain. The zygomatic processes bilaterally as well as the upper teeth were quite tender. There was a swelling noted over the maxilla bilaterally. Purulent drainage was noted in both nasal antral windows. Each maxillary antrum demonstrated thick erythematous mucosa obliterating the cavities. The patient was not febrile. CBC and sedimentation rate were normal; cultures of nasal drainage were negative. Sinus X-rays demonstrated bilateral opacification of the maxillary sinuses with clouding of the ethmoid sinuses (Fig. I).

Despite use of antibiotics and a course of systemic steroids, the patient's symptoms persisted. Therefore, in May, 1982, another Caldwell-Luc was performed. The sinus was lined by dense fibrotic tissue which bled freely. The tissue was firmly adherent to the bone and in several areas penetrated the remaining bone of the sinus. The residual ethmoid labyrinth demonstrated an identical picture. Postoperative hemostasis was achieved with antral balloons with saline being injected into the

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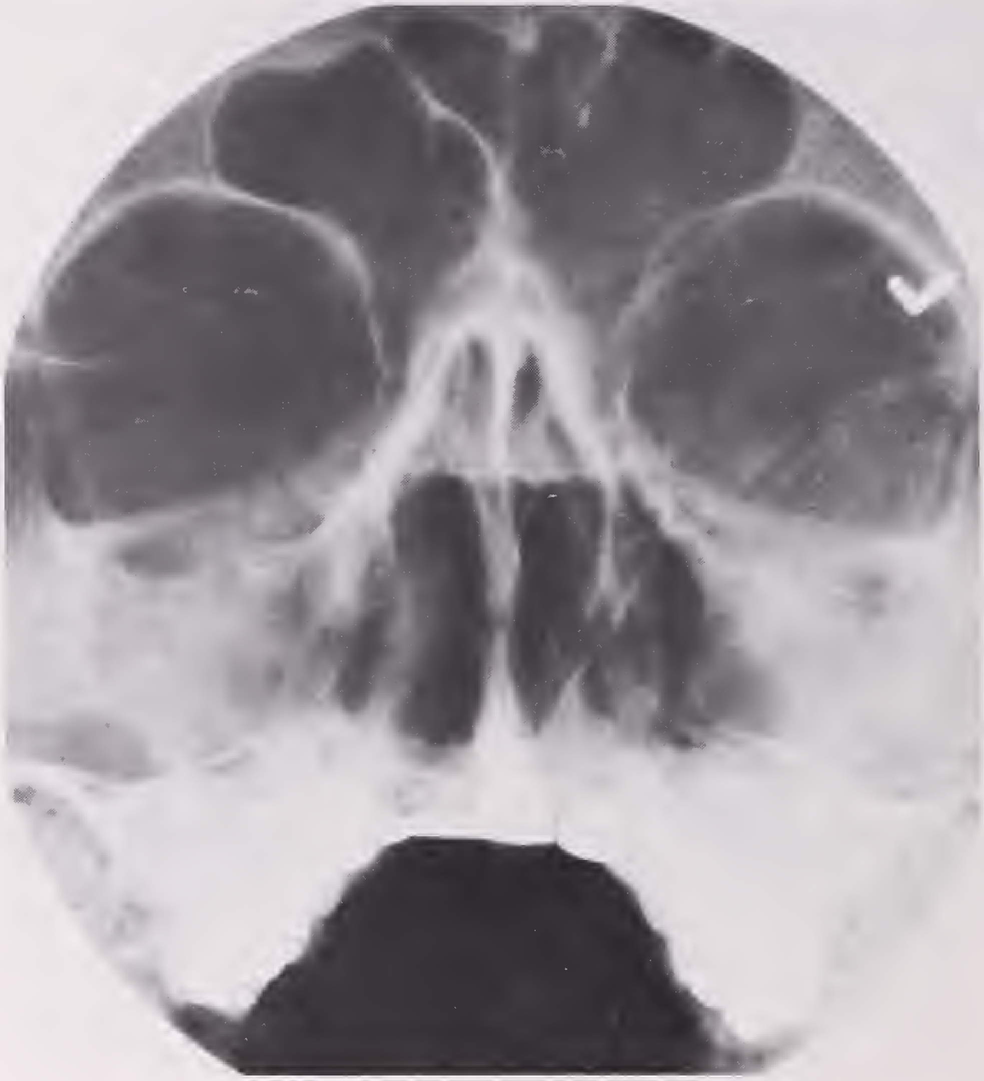

Figure I — Sinus x-rays showing bilateral opacification of the maxillary sinuses with clouding of the ethmoid sinuses.

nasal tampons. Tissue obtained from the maxillary sinus was sent to pathology and the diagnosis of myospherulosis was made.

Following surgery, the patient continued to complain of midfacial pain. X-rays demonstrated cloudiness of the maxillary sinuses with some improvement in the ethmoid sinuses. The membranes within the maxillary antra began to thicken and develop polypoid changes. Purulent drainage occurred with episodes of increased pain. Cultures grew mixed upper respiratory flora with staphlococcus aureus. Despite antibiotics, the pain persisted.

Two further attempts were made to remove the myospherulosis by curettage of the maxillary sinus. These proved to be unsuccessful. Severe facial pain continued, despite oral analgesics. In June 1984, the medial portion of the maxilla, the ethemoid sinus and medical portion of the orbits were excised to the extent that facial cosmetics could be preserved. Again, myospherulosis was found in these tissues. Facial pain, however, had been considerably reduced with the patient now resuming a more normal life style.

Discussion

Myospherulosis occurs in patients who have previously had petroleum based packs used during surgery. The majority of the cases in the United States have been in the nose or paranasal sinuses; but other sites have in-

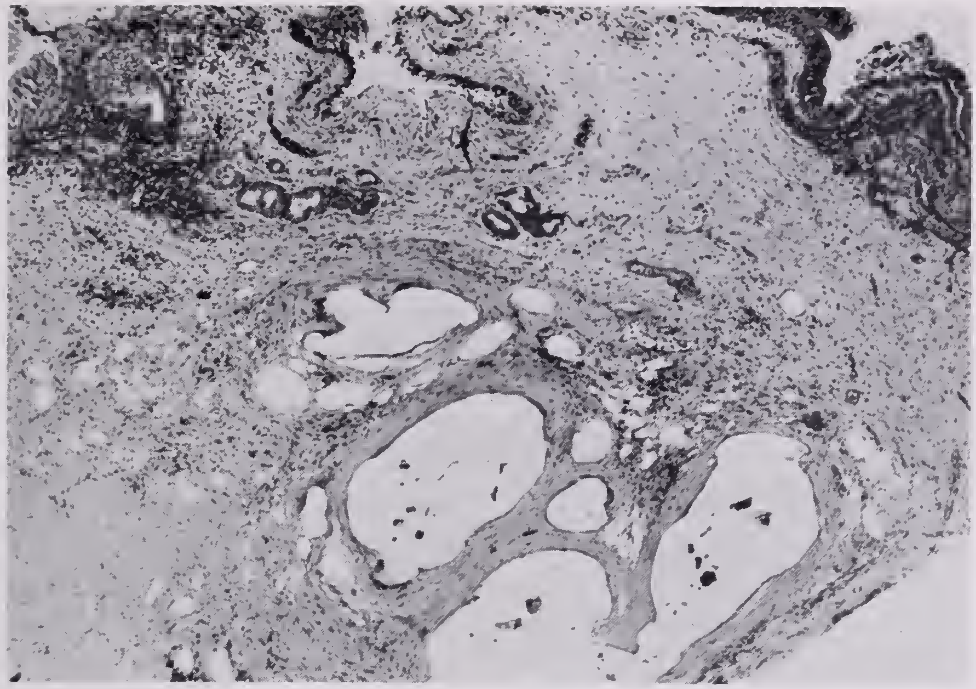

Figure II — Section of maxillary sinus demonstrating multiple cystic tissue spaces with "swiss-cheese" arrangement.

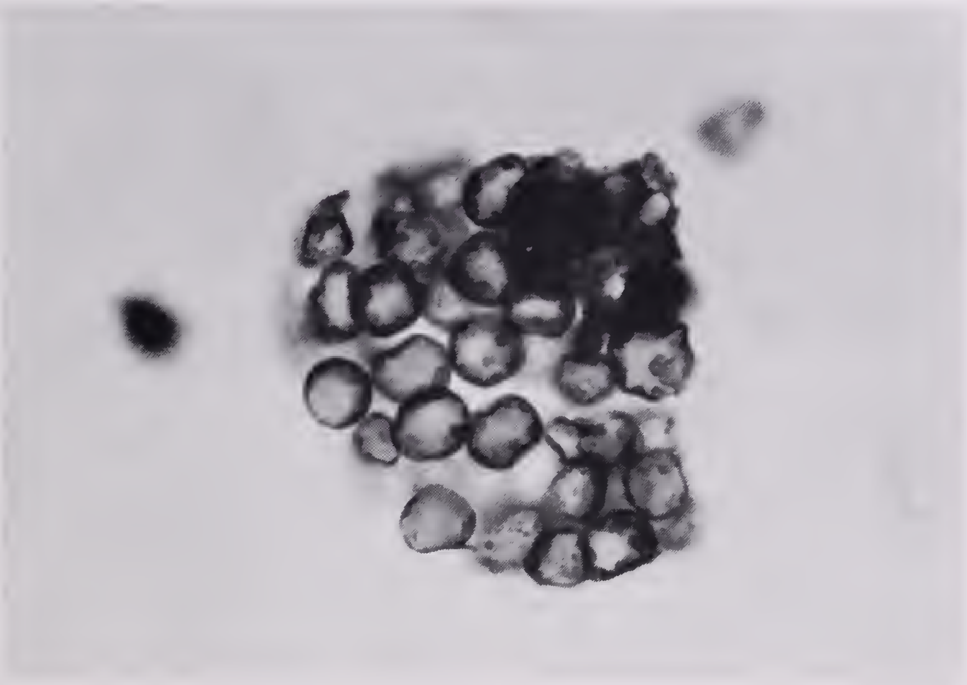

Figure III — Numerous clumped "spherules" after rupture from sac-like structure (parent cyst).

cluded dental sockets,[8] the middle ear and brain.[7] In the paranasal sinuses, pain is the principal symptom, with clinical findings suggestive of infectious sinusitis. X-rays demonstrate cloudiness or opacification of the sinuses with occasionally bony erosion.[4] Any of the sinuses may be involved, but the maxillary sinus is the most common site. Laboratory tests are not particularly helpful in making a diagnosis. CBC is usually normal while the sedimentation rate is normal or only slightly elevated. Cultures demonstrate no consistent etiologic agent. The patients are usually afebrile or have a very low grade fever.

Histologically, multiple tissue spaces are present with a "swiss cheese" arrangement (Figure 2). These spaces are lined by histiocytes or multinucleated foreign body giant cells. The surrounding tissue contains an admixture of acute and chronic inflammatory cells with fibroses. The brown myospherules are found within sac-like structures (parent cysts) in the tissue spaces (Figure 3). The cystic sacs have a double contoured wall and range from several microns to 1.0 mm in size, while the spherules within the sac range from four to seven microns in diameter.[7,10] The spherules may resemble fungi.

Treatment of this disorder is largely preventative. This is an iatrogenic disease and alternatives to the use of petroleum based packings should be sought. Dry gauze or saline impregnated gauze may be used. Antral balloons can also be employed. Nasal tampons devoid of petroleum are an acceptable alternative. In addition, sprays containing lanolin and petrolatum based ointments should be avoided in the postoperative period.

Once the disease is present, the only known treatment is surgical excision. The lesion is firm and rubbery, with a polypoid appearance. Excision is difficult due to adherence and frequent invasion of adjacent bone. The use of steroids is usually not effective in curing the disease.

Summary

Myospherulosis is an iatrogenic disease related to the application of petroleum based packing in the upper airway. Surgical excision so far has been the only known curative treatment. Pain is the major symptom. Clinically the disorder resembles a refractory sinusitis. Considering the consequences of the disease, avoidance of petroleum based ointments during and following surgery is strongly recommended.

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PERINATAL PAGE

The Importance of Accurate Pediatric Diagnosis of Cerebral Dysfunction or Should the Cesarean Section Rate be Increased?

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HUMAN beings carry a number of detrimental genes concerning neurological development and the in utero environment is not always optimal, which, acting singularly or together, may produce a newborn with subsequent developmental delays. Pediatric care should recognize these obstetrical limitations in determining either good or bad pediatric outcomes. Two cases are presented which show the difficulties presented to obstetricians because of inaccurate pediatric diagnosis.

Case I. A child of an unmarried teenager, who was initially planned for adoption, was born of an uneventful labor and delivery. The fetal heart rate tracings were well within the normal variation showing variable type of fetal heart rate decelerations as seen in approximately 50% of all labors. At birth the infant was noted to be "strange looking", was flaccid, and was intubated because it appeared to be "very limp" although it had spontaneous cry and respirations. The admitting diagnosis to the intensive care unit was "rule out asphyxia". No blood gas studies were ever done and the child never had any seizures or any specific problem other than mild jaundice during its newborn stay in the hospital. At time of discharge, it was signed out as dysmorphic without a specific diagnosis. At approximate age 2½ years, when the child was diagnosed as developmentally delayed, a note was made in the child's record that it had been "asphyxiated" at birth. This asphyxial concept was continued on in the records of the various consultants, and the parents sued the obstetrician. The fact that the child was dysmorphic was ignored by the jury and they awarded $3 million to the plaintiffs, apparently because the child was not delivered by cesarean section.

Case II. The third child born of a very small Asian female, who appeared to be of normal intelligence and whose other children were stated to be normal. During the course of pregnancy an ultrasound showed a relatively large head without evidence of hydrocephalus. She was also diagnosed to have gestational diabetes and was treated with low dose insulin. When the amniotic fluid indicated fetal lung maturity, she was induced and delivered with the aid of a vacuum extractor over an intact perineum. The newborn's Apgar scores were 7 and 9 and it was 1½ lbs. smaller than her other two infants who had weighed 9 lbs., 11 oz. and 9 lbs., 8 oz. The child was noted to have a large head at birth and be somewhat limp but otherwise did well and was discharged home to its mother. It was admitted to the hospital on at least three different occasions because of apparent developmental delay. The final diagnosis on his third admission was hydrocondroplasia with megencephaly. According to the pediatric admission notes, his delivery had required use of "forceps" with labor induced for cephalopelvic disproportion. Indeed, a senior pediatric specialist subsequently advised the obstetrician to deliver the mother's next child, which also showed megencephaly in utero on ultrasound, by cesarean section because the proband's delayed mental development may have reflected its "difficult forceps delivery". While the delivery record was available for all to see, the pediatric staff accepted the mother's belief that she had a difficult forceps delivery, which, in reality, had never occurred.

It is important that the nature of the delivery be accurately recorded on all the infants' charts, and that the parents' statements concerning the delivery never be considered at face value. In both of these cases presented, the mothers firmly believe that the obstetrical management was less than optimal, perhaps reinforced by the impression carried through the various pediatric medical notes. In view of the possible parent, pediatric, and jury subsequent erroneous evaluations, it may indeed be indicated to suggest cesarean section whenever the fetus is known to be abnormal and expected to survive. Given nationwide cesarean section rates of 16 to 22%, delivering all known abnormal fetuses (1-2%) by the abdominal route would not appreciably increase the rate of cesarean sections. Such elective cesarean sections would not be expected to improve the newborn's outcome and would carry the risks and costs of major surgery for the mother, but this type of delivery might assure all of the involved individuals that everything was done from an obstetrical standpoint to achieve an optimal newborn outcome.

WashingtoNotes

New NIH Guidelines

A new report from the Institutes of Medicine (IOM) warns against further expansion of the National Institutes of Health (NIH), but urges NIH to become more aggressive in its response to public health needs.

If NIH does a better job at responding to health emergencies, perhaps Congress will ease up on efforts to create new institutes, the IOM report suggests.

The report was prepared by a 15-member IOM committee over the past 18 months, in response to a request by the Department of Health and Human Services to study the organizational structure of NIH. The committee received written comments from 145 organizations and individuals and interviewed 185 people, including members of NIH, HHS, Congress, and the scientific and medical communities.

Part of the report received a warm reception: virtually everyone agrees that the NIH Director deserves more freedom to respond to sudden research needs. Proposals which give the NIH Director access to a discretionary fund and the authority to transfer some funds across NIH institute lines were endorsed by both the research and congressional community.

There is dispute, however, over the report's criteria for estabishing new institutes. Since 1970, there have been 23 separate proposals for new institutes. Researchers say that the once-unified mission of NIH has become fractured and splintered as disease groups lobby for special attention.

The most recent push for NIH reorganization, which would have authorized a new arthritis institute and nursing institute, was vetoed by President Reagan in November.

* * *

Wennberg Method Proposed to Reduce Variations

A greatly expanded federal investment to reduce variations in medical practice from community to community might save Medicare up to $16 billion a year and reduce surgical death rates in the process, says a physician epidemiologist who has studied such variations for 10 years.

Dartmouth professor John Wennberg, M.D., wants Medicare and Medicaid to follow industry's example of setting aside a specific percentage of expenditures for research. He has suggested that about 0.5% of the Medicare

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President's Page

"MEDICINE IN TRANSITION"

Corporate Medicine and Contracts

Herbert E. Reese, M.D.

Medicine today is in rapid transition. It is undergoing its third major transformation of this century — this time on the basis of cost pressure. The first transition was approximately in 1900 and could best be termed the scientific transition. This transformation was spurred on by the Flexner report in 1910, which was the stimulus that brought medicine "out of the dark ages" and started revolutionizing the scientific approach to medical practice. And since 1900, the death rate has been cut in half with approximately 30 years added to the life expectancy at birth. The second major transition was social-political and started approximately in 1945. This transformation included the Hill Burton Act for hospital construction, expansion of the number of medical schools from 84 to 142, and insurance coverage for about 90% of all Americans. This change was followed by the government's decision in 1954 to make health care costs deductible and then came government programs of medicare, medicaid, and subsidization of Health Maintenance Organizations (HMO's). This was the open-ended era with health care becoming a God-given and government-given right. We are now in the midst of another great transition best called the industrialization of medicine or corporate medicine. We, in Nebraska, have been fairly well insulated from this transition in the past several years, but we can observe this remarkable transformation in our surrounding states and in the nation. Now no one can deny that it has arrived in Nebraska. Several HMO's are operative in Omaha and Lincoln with several others, along with preferred provider organizations (PPO's) and independent practice associations (IPA's), in the planning phases. We are seeing for-profit corporations managing pre-paid plans and institutions, as well as for-profit corporations with ownership of institutions. Blue Cross/Blue Shield plans to initiate a statewide HMO by mid 1985.

In this active transition there are several players: (1) The public who want the best health care at the lowest cost. (2) The physicians who desire independent professionalism to preserve patient advocacy with individuality, confidentiality, and personal interaction based on longstanding ethics and standards. (3) The non-profit hospitals who want to survive in this competitive marketplace and uncertain trends. With these changes, there is inceasing tension between institutions and between institutions and doctors who are competing for their share of the marketplace. Increasing tensions are created and yet mutual support is a necessity as hospitals don't survive without physicians nor do physicians survive without their hospitals. (4) The large insurance organizations, which include Blue Cross/Blue Shield, and other commercials who operate in every state. They collectively operate over 100 HMO's nationally. With their financial resources and size, they will be a most important force in the change in the delivery system. (5) The government and business who are determined to cut health care costs; and (6) The corporate medicine complex which is one of the fastest growing health care providers in America with hospital chains growing approximately 25% a year and an even more rapid growth of prepaid medical plans.

The multi-state for-profit HMO's have attracted large private investment interests with over 280 million private dollars invested in 1983 alone. These large corporations are well-financed and frequently inter-related financially and administratively. Medical services are now being approached as a commodity. Many managers and economists feel that physicians will become salaried functionaries of these organizations and that these competitive models will solve the health care problems of America. It appears that we physicians are moving from being the advocate of the patient for his welfare, wants, and needs to being the allocator of services for the patient regarding benefits, costs, and profits. As much as we see many adverse problems with the patient's welfare in this system, the system is here. We are rapidly becoming the center of a multi-billion dollar industry with the emphasis on competition, marketing, capitation, lowest bids, costs,and profits. Richard Reece, M.D., Editor of Minnesota Medical Association, said it best ". . . the proposition that higher quality necessarily follows if you transfer care from individual physicians or small groups of physicians to large organized groups who bid lower prices for services strikes me as the work of someone who has taken the 'Oath of Hypocrisy'." The corporate medicine complex, however, will have to be recognized and, indeed, has some real strengths, such as large capital resources, efficient management, economies of scale, and a hard-nosed financial attitude against waste. There are also some definite weaknesses. The corporations look at health care as a commodity or product with cost to be minimized and profits to be maximized. They are allocators of services and benefits with close attention to costs and the bottom line. This health climate may not fulfill the wants and needs of individual patients. Physicians are involved and will need to be involved particularly in the commitment to quality, cost containment policies, and management. Physicians no longer can be an independent professional with little concern for business. It is now imperative that the physician also be a businessman.

We are now seeing various contracts related to our services with many of these new organizations. Many physicians like myself have always felt that contracts were something for the lawyer to read and understand; but today these contracts we are seeing have to be carefully studied and reviewed with expertise for there are many professional, liable, ethical, and financial implications involved.

Richard Robinson from the California Medical Society has pointed out seven sensitive areas that must be carefully reviewed in these contracts. 1) The first issue is the restriction on referral patterns. Restriction on referral patterns may have a very important implication regarding contractural and professional liability as well as possibly disrupting established referral patterns. 2) The second issue is "hold harmless" clauses or indeminification which shifts the liability to the individual physician. Professional liability usually does not cover contractual liability. 3) The third issue is the open ended utilization review clause. These clauses frequently have severe ethical and professional implications where they may actually curtial services and define what services are going to be rendered. In essence, they may direct how the physician is going to practice medicine but, indeed, he or she will still be liable. These review clauses have great implications regarding your professional liability coverage. Physicians are also reminded that traditional state immunities provided to physicians undertaking peer review on the hospital medical staff or medical society setting may not apply to peer review taking place under contract. 4) The fourth issue is the termination clauses. Many of these contracts make it difficult to terminate contractural relationships. Furthermore, physicians may be liable for abandonment of patients if they discontinue services to patients on the sole fact of termination of the contract. 5) The fifth issue is turn around time on claims which obviously is very important to the cash flow of the practice. 6) The sixth issue is the requirements for professional liability insurance. There are many reasons why this restriction has to be reviewed carefully by the physician and one's advisers and carriers. 7) 7) The seventh issue is arbitration. Here physicians should note that arbitration can be a very expensive procedure. In addition the agreement to arbitrate any and all disputes may preclude a physician from pursuing a claim through litigation.

These seven issues are in no way comprehensive; they only point out some of the many sensitive issues found in these contracts. The mailing from the Nebraska Medical Association on "Contract Medicine" points out some thirty issues that need to be carefully weighed before one signs a contract. This document on "Contract Medicine" should be carefully studied, but it cannot substitute for advice which should come from one's personal attorney.

It would appear a contract should be signed only if it is fair to you as the physician. Does the contract allow the physician to deliver quality care, and is the contract fair to the patient?

Herbert E. Reese, M.D.

WashingtoNotes

(Continued from page 62)

trust fund outlays be devoted to this purpose. At estimated 1984 spending levels this would amount to nearly $300 billion if all spending were included.

The research Dr. Wennberg has in mind would monitor and compare surgical and hospital admission rates community by community. It would also compare the outcomes of alternative treatments for some conditions where physicians don't agree on the best approach.

In addition, the Dartmouth medical school professor thinks federal funding to medical schools should be contingent on the schools' teaching statistical and epidemiological techniques that would help physicians choose between treatments.

His premise is that with documentation of the variations and better outcome studies, physicians will voluntarily reduce the variations. Since he has found low utilization rates among some teaching hospitals, he believes uses rates — and therefore costs — can be lowered without harming quality. In many cases, he suggests, care would simply be shifted from hospitals to physicians' offices so physicians' incomes would not be greatly affected by the change.

One indication of the growing attention Wennberg's methodology is attracting came at a November 19 hearing of the Senate Appropriations Subcommittee on Health and Human Services. Hearing Chairman Senator William Proxmire (D-WI) said he sees the Wennberg approach as a possible way to avoid cuts in Medicare benefits. A variety of witnesses, including the American Medicare Peer Review Association, the Washington Business Group on Health, and the American Medical Association supported Wennberg's approach but had different interpretations of it.

AMA representative James E. Davis, M.D., speaker of the Association's House of Delegates, emphasized that medical societies have participated in some of Dr. Wennberg's studies and saw as one of its virtues the emphasis on "voluntary practice modification rather than intrusive governmental intervention."

The Durham, North Carolina surgeon added, that while the AMA does believe that "wide variations" in care "should be examined closely," they may be "an indicator" of the "failure to provide care" as well as a signal that inappropriate care has been provided.

AMPRA Vice President Thomas Dehn, M.D., whose organization represents physician-directed peer review groups, including some of the new PROs, said Dr. Wennberg's work points to the need to extend PRO reviews into outpatient settings.

Washington Business Group on Health executive Willis Goldbeck saw the Dartmouth researchers' findings as evidence that business needs more data on hospital and physicians, and that Congress should require a relicensure system for physicians. Although Goldbeck also implied that some practice variations stem from usual, customary and reasonable payments, Wennberg himself has said that the

(Continued on page 70)

REPORT OF COMMISSION ON PUBLIC RELATIONS

Promoting the Physician as Patient Advocate

RODNEY S. W. BASLER, M.D., Chairman

The operating premise for the Commission on Public Affairs of the Nebraska Medical Association is that "the physicians of this state are continuing to do their jobs well, and the people need to be told about it". During this period which NMA President, Dr. Herb Reese, has so appropriately labeled "Medicine in Transition", patients are probably more eagerly looking for a health care advocate. Only the physician has the combination of training, experience, information and compassion to serve in that role.

The Commission is acting on this premise in two separate directions. First, we are evaluating the attitudes and opinions of the NMA membership, as disclosed by responses to the Association's recent professionally-administered internal poll. The Commission is trying to determine those positive attributes of which we, as members, wish to make the public especially aware. Second, we are attempting to present these positive accomplishments to the general public in such a way as to stimulate their support.

Current activities of the Commisison aimed at improving public relations through gratuitous public service include the preparation and distribution on a regular monthly basis of "Health Tips" and other news releases which describe new medical findings in terms easily understood by laymen. These short subjects are released to local newsppers and radio stations across the state.

Newspapers receive copies of the NMA President's annual "State of the Health" report which is produced for media representatives. Radio stations also have made available to them recorded "spots" on health items by the NMA President which they often use. In addition, the Commission coordinates member participation in the televised "Health Line" series, and secures appropriate spokespersons for conferences and media interviews.

New programs which have already been undertaken by the Commission in the direction of internal relations include **Nebraska Medical Journal** articles, such as this one, informing of NMA commission, committee and task force activities. An educational program aimed at members of the medical community who have not yet joined the NMA is progressing from the planning stage.

A number of new projects have been initiated which are intended to advance the concept of the physician as patient advocate among the general public. Included in these is the promotion of fitness, good health habits, and the attitude of wellness through news releases and eventually a video tape file. Better exposure to the press of selected **Nebraska Medical Journal** articles, including interviews with the authors, is expected to both increase lay interest and awareness, and stimulate more state physicians to become contributors. Formal and informal coalitions with leaders of business and labor are being explored. Also in the planning stage is a booklet explaining to patients the various forms of health insurance and distribution systems, with the advantages and disadvantages of each.

And finally, a means of formally presenting a catalogue of organized medicine's many accomplishments is being considered. One possibility is the production of a descriptive pamphlet for office waiting room distribution, discussing items such as NMF student loans and scholarships, CME accreditation, tumor registries,peer review, and the Health Gallery with the mobile van in which we can justifiably take pride.

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In Memoriam

By medicine life may be prolong'd
yet death
Will seize the doctor too.
—Shakespeare

William E. Wright, M.D. — (Born 1892 - died November, 1984) — Medical Specialty — General Practice. Doctor Wright was a graduate of the University of Nebraska College of Medicine in 1925. He was a member of the American Medical Association, Nebraska Medical Association and a past president of the NMA. He is survived by his wife, one son, Doctor W. E. Wright of Mondovi, six grandchildren and two great-grandchildren.

Bulent Tunakan, M.D. — (Born March 31, 1924 - died November 7, 1984) — Medical Specialty — Psychiatry. Doctor Tunakan was a graduate of the University of Istanbul School of Medicine in Turkey in 1949. He was a member of the American Medical Association and the Nebraska Medical Association.

Coming Meetings

1985 ANNUAL SESSION — April 26-29 — Lincoln Cornhusker

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

THE MATERNAL AND CHILD NUTRITION CONFERENCE — March 28-29, 1985. The focus of the meeting will be on the medical, nutritional, and social implications of teenage pregnancy. The location of the meeting is the East Campus Union, University of Nebraska, Lincoln, NE. Continuing education credits have been applied for from the American Dietetic Association, Nebraska Nurses Association and the Dietary Managers Association. Cost for the two days will be $25.00. For more information contact Eileen Douglass, Nebraska Department of Health - Nutrition Division, 301 Centennial Mall, South, P.O. Box 95007, Lincoln, NE 68509. Phone (402) 471-2781.

CREIGHTON UNIVERSITY

CLINICAL ENDOCRINOLOGY & NEPHROLOGY FOR THE PRACTICING PHYSICIAN, Feb. 2-9, 1985, Ocho Rios, Jamaica. Program Director: Paul Steffes, M.D. For information: CME office (402) 280-2550.

CARDIOLOGY: STATE OF THE ART, Feb. 9-16, 1985, Puerto Vallarta, Mexico. Program Director: Syed Mohiuddin, M.D. For information: CME office (402) 280-2550.

CARDIOPULMONARY DISEASE, Feb. 16-23, 1985, Ocho Rios, Jamaica. Program Director: Walter O'Donohue, Jr., M.D. For information: CME office (402) 280-2550.

MEDICAL & SURGICAL ONCOLOGY FOR PRIMARY PRACTITIONERS & GENERAL SURGEONS, Feb. 23 - Mar. 3, 1985, Puerto Vallarta, Mexico. Program Director: James Mailliard, M.D. For information: CME office (402) 280-2550.

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 3-8, 1985. Sponsors: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 25 hrs. AMA Category I. Fee: $400 Physicians, $200 Residents. Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology, Endocrinology, Pediatric and Adult Cardiology.

UNIVERSITY OF KANSAS

For additional information on the following University of Kansas meetings contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, KS 66103, Telephone (913) 588-4480.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — February 21-22, June 13-14, 1985. Sponsor: University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 16 hrs - AMA Cat. I, 15 hrs. - AAFP. Fee: $600. Maximum attendance: 9.

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 2-9, 1985. Sponsor: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 24 hrs. AMA Category I, 24 hrs. AAFP. Fee: $400 Physicians, $200 Residents.

Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology Endocrinology, Pediatric and Adult Cardiology. Contact Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Ave., Omaha, NE 68105, (402) 559-4152.

ADVANCED CARDIAC LIFE SUPPORT — March 20-21, 1985, May 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Building, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $150 physicians, $75 nurses, EMTs. Credit: 13.5 hrs. AMA Cat. I, 13.5 hrs. AAFP, American Heart Association Certification.

REHABILITATION MEDICINE: OFFICE MANAGEMENT OF MUSCULOSKELETAL PAIN SYNDROME — March 25-26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: Hours TBA for Physicians, Nurses, Physical Therapists.

COMMUNICATING WITH CHILDREN (HEARING AND SPEECH) — April 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians and Speech/Language/Hearing Clinicians.

35TH ANNUAL SYMPOSIUM ON ANESTHESIOLOGY — April 19-21, 1985. Sponsor: University of Kansas Medical Center. Location: Westin Crown Center Hotel, One Pershing Road, Kansas City, Missouri. Credit: 15.5 hrs. AMA Cat. I, 14 hrs. AAFP, 14 hrs. AANA. Fee: $225 Physicians, $150 Nurse Anesthetists.

11TH ANNUAL FAMILY PRACTICE SYMPOSIUM — April 24-25, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for physicians.

29TH ANNUAL SYMPOSIUM ON INFECTIOUS DISEASE — April 26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

ANNUAL PATHOLOGY SYMPOSIUM — April 27, 1985. Sponsor: University of Kansas Medical Center. Location: Rieke Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

SAM E. ROBERTS NUTRITION PROGRAM: MINERALS IN HUMAN NUTRITION — CLINICAL APPLICATION — April 30, 1985. Sponsor: Academy of Health Professions and University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $100 Physicians, $40 Nurses, Dietitians, Allied Health Professionals, no charge to students and residents. Credit: 7 contact hours each for physicians, nurses, dietitians, physical therapists, and respiratory therapists. Contact: Ida Tilden, Academy of Health Professions, 2920 McGee Trafficway, Kansas City, MO 64108, (816) 531-4559.

SCHEDULED MEETINGS

37TH ANNUAL MIDWEST CANCER CONFERENCE — March 8-9, 1985, Hilton Inn East, Kellogg and Rock Road, Wichita, KS. Friday Session — Title: Breast Cancer: Can We Reach a Consensus? Saturday Session — Title: Effective Screening for Colon Cancer: Flexible Sigmoidoscopy. Title: Skin Cancer: Selected Topics.

WashingtoNotes

(Continued from page 65)

variations are a "worldwide phenomenon not explained by incentives associated with fee for service medicine."

Health Care Financing Administration staff, who are clearly uneasy with the prospect of a Medicare set-aside for research, maintained that the recent advent of a Medicare prospective payment system and peer review organizations (PROs) are already encouraging physicians to rethink their practice patterns. Nevertheless, HCFA official Henry Desmarais, M.D., announced, the agency is "considering" Dr. Wennberg's method as "one of several approached within the new PRO program to further refine the identification of variations in physician patterns." Some PRO officials have reported that HCFA is negotiating a demonstration of a Wennberg computer program by the Iowa PRO.

* * *

President Challenges New Council on Health Care Technology

In a tersely worded message to Congress, President Reagan this month warned that he would not request funding for the new Council on Health Care Technology, a quasi-private clearinghouse for technology assessment.

Although Reagan signed S-771, which authorized the Council, he noted "strong objection" to the constitutionality of the group.

The Council would be composed of members chosen by the federal Department of Health and Human Services and the private National Academy of Sciences, including federal officials, members of the general public, and representatives of the fields of medicine, law, ethics, economics, and management.

Reagan contended that the council would mix governmental and non-governmental, executive and legislative elements "in a manner which is inconsistent both with the Constitution and with sound government practices," he said. Because the Council would perform government duties, it is unconstitutional for its members to be selected by a nongovernmental agency, he noted.

The President asked Congress to go back to the drawing board, revamping the structure and function of the Council. Until such remedial legislation, he will refuse to ask for funding for the Council in his January budget.

* * *

Another Blow to Depo-Provera

Citing inadequate research, a Food and Drug Administration advisory panel has recommended that the injectible contraceptive Depo-Provera not be approved for sale in the U.S.

The panel of three university scientists said that data linking the long-term use of the drug to cancer in animals should not be ignored. Depo-Provera was found to produce breast cancer in beagles over a 7-year period and endometrial cancer in monkeys over a 10-year period.

The panel's recommendation, endorsed by other FDA scientists, now goes to FDA Commissioner Frank E. Young, M.D., for a final decision. If Dr. Young agrees with the panel's conclusion, as expected, manufacturer Upjohn Co. may go to court to have the FDA action overturned.

Depo-Provera, approved in 80 foreign countries, has been used by 11 million women around the world. If approved in the U.S., an estimated 4 million women may have shifted over from other contraceptives. Additionally, the drug could have been used in overseas population programs sponsored by the U.S. Agency for International Development.

The drug is effective for over three months and requires less patient motivation than the pill or barrier contraceptives. It is injected into the muscle of the upper arm or buttock and released slowly into the bloodstream from the injection site. It can be administered by any person who normally gives injections.

It prevents ovulation by suppressing hormone production by the hypothalamus and pituitary. Secondary effects, such as changing the cervical mucus, the uterine lining, and the Fallopian tubes, also reduce fertility.

Its use is endorsed by a wide variety of health and population groups, such as the World Health Organization, the American College of Obstetrics and Gynecology, the International Planned Parenthood Federation, and the Population Crisis Committee.

Opponents include FDA staff scientists, individual scientists from the National Cancer Institute, the Centers for Disease Control, and consumer advocacy groups such as the National Women's Health Network and the Health Research Group.

* * *

FDA Considers Banning Sale of Raw Milk

The Food and Drug Administration (FDA) is considering a regulation that would ban the sale of raw milk, in hopes of reducing cases of bacteria-linked poisoning.

Advocates of raw milk contend that pasteurization reduces levels of thiamin, vitamins B-12 and C, calcium, protein, and fat. Raw milk has been claimed to contain beneficial enzymes, hormones, and anti-stiffness agents for treatment of arthritis.

Many recent outbreaks of salmonellosis, however, prompted government officials to take a closer look at raw milk. Milk is an ideal growth medium for Salmonella, they discovered, causing severe diarrhea, abdominal cramps, and sometimes death. California health authorities have calculated that the risk of Salmonella dublin infection is 84 times higher in persons who consume raw milk than in persons who consume pasteurized milk.

Moreover, pasteurization causes no major loss of nutrients, FDA researchers found. There is no evidence that raw milk enhances resistance to disease, improves fertility, or reduces stiffness, they say. The so-called beneficial enzymes inactivated by pasteurization are also inactivated by gastric acidity and hormones are unaffected by the pasteurization process, they note.

FDA's proposal was applauded by the AMA, which believes that all milk sold for human consumption should be pasteurized. "There is convincing scientific evidence that raw milk poses a significant public health risk," said AMA Executive Vice President James H. Sammons, M.D. "Pasteurization kills the bacteria that transmit disease to humans."

* * *

Court Orders Nursing Home Inspection Guidelines

A federal court in Denver has ordered the Department of Health and Human Services to rewrite guidelines for inspecting the nation's 18,000 nursing homes to emphasize actual care of patients rather than the structure of the home.

The ruling by the U.S. Court of Appeals comes as a prestigious national committee is holding a series of public hearings on nursing home standards and regulations and as both states and the federal government are beginning to look for better ways of monitoring the care nursing home patients receive. Federal officials said they haven't yet assessed the potential impact of the Colorado suit and haven't decided whether or not to appeal the decision.

The suit was based on the argument that by concentrating on structural issues, federal Medicare and Medicaid standards concentrate only on the homes' potential to provide care rather than the quality of care actually provided.

Although a lower court ruled that enforcement of nursing home standards is a state responsibility, the appeals court found that HHS was not meeting a statutory obligation to assure that nursing home patients receive quality care and instructed the lower court to "compel" the department to meet its obligations in this area.

The issue raised in the Colorado decision involves a long argument over the types of standards nursing homes participating in Medicare and Medicaid should be required to meet and how they should be monitored.

It was put on hold when congress directed HHS to hold off on any changes in the enforcement procedures for a short time and then won a "gentleman's agreement" with the department that changes in the conditions of participation and inspection process would be delayed pending the recommendations of a national commission.

The commission, which was formed through the National Institutes of Medicine, is now conducting public hearings and expects to issue its final recommendations in July, 1985. Congress in the interim also increased the funds for inspection which rose to $73.6 million in 1983 and were at $72.5 million in 1984.

Meanwhile several states have initiated new inspection and survey methods aimed at looking less at facilities' physician structure and more at the end result in terms of quality of care and the degree to which the patients' other needs are met as well. The Health Care Financing Administration is involved in five of the state efforts and is also experimenting with a new national survey instrument. Both the nursing home industry and patients rights groups support a move to an outcome oriented approach.

* * *

Cancer Rates Improving

Survival rates for cancer victims are showing a slow but gradual improvement, climbing from 48% for patients diagnosed from 1973-75 to 49% for patients diagnosed from 1976-81, according to new National Cancer Institute (NCI) statistics.

Most noteworthy are gains in survival of cancers of the lung (12-13%), colon (49-52%), and prostate (64-70%).

Overall there were gains against rare diseases such as testicular cancer, Hodgkin's disease, melanoma, and the vast array of childhood cancers and leukemias, but little progress in the more common cancers of the breast and endometrium.

Cancers with the highest five-year survival rates are: thyroid cancer, 93%; testis cancer, 86%; endometrium cancer, 85%, melanoma, 80%; female breast cancer, 74%; bladder cancer, 73%; Hodgkin's disease, 73%; and uterine and larynx cancers, 67%. Cancers with the lowest survival rates are: pancreas cancer, 2%; esophagus cancer, 5%, and stomach cancer, 16%.

In some cases, NCI says increased survival rates are due to improved drug therapy; in others the turn around is due to better recognition of early lesions by patients.

* * *

FDA Offers Help to Halt Fraudulent Medical Ads

The Food and Drug Administration (FDA) and the Council of Better Business Bureaus have asked the nation's radio and TV stations to review medical claims carefuly before accepting them in advertisements.

To help, FDA and the Council are mailing 10,000 sales managers information about how to recognize medical product frauds. The mailing suggests careful checking of proposed ads that depend on sensational or foreign testimonials, state or imply that established medicine is covering up a "breakthrough," or have vaguely worded "money back" guarantees.

If TV and radio sales managers have questions about a claim or company, the Council and FDA are ready to help. A similar mailing was sent to newspapers and magazines in May.

Among bogus products as frauds are "miracle" weight reducers, herbs and health foods sold with disease claims, body wraps, sex aids, arthritis and cancer "cures," simplistic tests for diet deficiencies and allergies, anti-aging products, sobriety aids and multi-purpose elixirs and treatments.

* * *

Medical PACs Came of Age in 1984 Elections

Behind the scenes in recent elections, political action committees (PACs) quietly have come of age. Strong and savvy, they have established themselves as major fixtures on Washington's political scene.

Nowhere is this more evident than in health PACs. AMA's PAC (AMPAC), once the only major contributor to health-oriented candidates, has been joined by more than 100 smaller, more specialized contributors.

AMPAC boosted spending 60% during this election cycle, from $2.4 million in 1981 to an estimated $3.5 million in 1984. Abbott Labs increased contributions 28%; Eli Lilly increased contributions 22%. Hospital chains, medical device companies, medical specialty societies, and non-physician professionals all report healthy spending levels.

Candidates who once spurned a PAC's advances this year turned to them for help. PAC spokesman say they received unprecented numbers of invitations to campaign cocktail parties and dinner fundraisers.

Even some staunch opponents of PACs have adopted a "if you can't beat 'em, join 'em" philosophy and contributed to politicians who best represent their interests.

Some of the changes noted in fundraising this past election cycle:

* Earlier spending — larger "war chests" of contributions are carried from election to election, saved for future use. Supporters of this accelerated spending say that "early money" makes candidates less vulnerable to the debts incurred by their re-election campaign.

* Increased pressure — as the cost of running for office climbs, candidates must look for new ways to make ends meet. "Reverse lobbying," in which candidates solicit PACs, is now the trend. Some large PACs ask challengers to fill out questionnaires, complete "position paper" and discuss issues. Even small PACs say they receive daily invitations to fundraising parties.

* More risk taking — as PACs become more adept at identifying qualified challengers, they have shifted away from the play-it-safe approach of backing only incumbents and are making a greater effort to locate those challengers who support their interests.

* Restricted spending — increasingly, PACs look for ways to exert the greatest influence on the handful of Congressional candidates they most want in office. FEC's limits on PAC spending can be sidestepped by "independent expenditures;" as long as a PAC has no contact with a candidate or his campaign, there is no ceiling on the amount it spends. Spending was very high in this area in 1984.

* Greater specialization — not long ago, AMPAC was the only medical PAC in town. Now, there are PACs for pathologists, psychiatrists, emergency physicians, and oral and maxillofacial surgeons. Black physicians are represented by the National Medical Association PAC; public health physicians, Public Health PAC; and anti-war physicians, Medical Associates for Peace PAC. Non-physician health PAC are also active; in the 1983-84 election cycle, dentists spent roughly $679-680; chiropractors, $213,814; nurses, $185,662; optometrists, $177,974; podiatrists, $134,954 and so on.

* Changed expectations — gone are the days when a voting record could pinpoint candidates who were for or against medicine. The battle lines are often blurred. PACs now look for legislators who share philosophical leanings, or who are particularly knowledgable about a certain area of health.

* * *

Fauci to Head NIAID

Anthony S. Fauci, M.D., and internationally renowned expert on the immune system and AIDS research, has been appointed director of the National Institute of Allergy and Infectious Diseases.

Dr. Fauci, 43, has been chief of NIAID's Laboratory of Immunoregulation since 1980 and deputy clinical director of the Institute since 1977. Former NIAID director Richard W. Krause, M.D., left last summer to become dean of the school of medicine at Emory University in Atlanta.

Dr. Fauci received his M.D. degree from Cornell University Medical College, served his internship and residency at the New York Hospital-Cornell Medical Center, and joined NIAID as senior investigator in the laboratory of clinical investigation in 1972.

* * *

Mittemeyer Resignation

Army Surgeon General Bernhard Mittemeyer, M.D., will leave his position in early 1985 to become Vice President and Medical Director of a Los Angeles-based medical management firm, the Whittaker Corporation.

Dr. Mittemeyer, a board-certified urologist, took over as Army Surgeon General three years ago. Prior to his appointment, he was commanding general of Walter Reed Army Medical Center in Washington, D.C.

Dr. Mittemeyer serves in the AMA House of Delegates and on the Board of Regents of the Uniformed Services University of Health Sciences in Bethesda, Maryland.

* * *

New National Institute of Mental Health Director

Chervert H. Frazier, M.D., will assume the post of new director of the National Institute of Health before the end of the year.

Dr. Frazier joins NIMH from Harvard Medical School where he was professor of psychiatry, and from McLean Hospital in Belmont, MA, where he was psychiatrist-in-chief since 1972.

Prior to his service in Massachusetts, Dr. Frazier was professor and chairman, of the Department of Psychiatry, Baylor University College of Medicine; consultant psychiatrist at Rice University; and former commissioner of Mental Health and Mental Retardation for the State of Texas.

* * *

VA to Backstop Military Medicine in Event of War

The Veterans Administration, the traditional provider of care to veterans, now has a new mission: to backup the Department of Defense in the event of a war or national emergency.

Results of a new survey show that the VA can promise the military 19,000 beds within 72 hours and 31,000 beds within 30-45 days.

Service-connected veterans still will be first priority for the VA system. Non-service-connected veterans, however, will be transferred to private hospitals to make room for incoming servicemen.

The VA would receive patients as the DoD's medical facilities become saturated. When the VA's beds are filled, military casualties will be sent to backup civilian hospitals. In practice, the very seriously wounded patients — those with spinal cord injuries, burns, and blindness, for instance — would be shipped immediately to VA facilities for long-term care.

The system, part of a larger VA-DoD sharing plan enacted into law in 1982, was prompted by increasing concern over the cost of medical care in the nation's federal hospitals. The law, PL 97-174, upgrades the priority for VA care of the active duty casualty and gives the VA the flexibility it needs to enter into long-range plans with DoD.

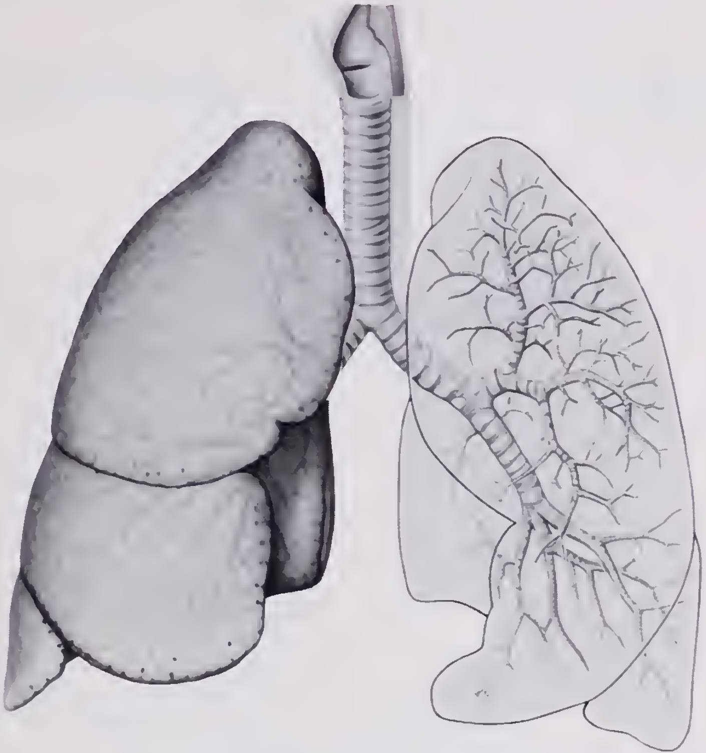
The system depends on 71 primary receiving hospitals to care for the first wave of casualties. The hospitals were chosen because they are near the point of military debarkation, contain at least 150 beds, and are within 50 miles of a VA or DoD coordinating center.

Secondary receiving hospitals, although less well-equipped for a major influx of casualties, will share resources and accept patients from the primary receiving hospitals. Third tier installation support centers will provide health care support to medical personnel deployed out in the field.

All 28 VA medical districts have established contingency planning task forces that have been cleared by the district and regional levels and are now awaiting the final review at the national headquarters in Washington.

* * *

Consider the causative organisms...



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250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

t Summary. Consult the package literature for prescribing
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cations and Usage: Ceclor® (cefaclor, Lilly) is indicated in the
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ower respiratory infections, including pneumonia caused by
ptococcus pneumoniae (Diplococcus pneumoniae), Haemoph-
influenzae and *S. pyogenes* (group A beta-hemolytic
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traindication: Ceclor is contraindicated in patients with known
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nings. IN PENICILLIN-SENSITIVE PATIENTS, CEPHALO-
RIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY
RE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL
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ntibiotics, including Ceclor should be administered cautiously
ny patient who has demonstrated some form of allergy
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seudomembranous colitis has been reported with virtually all
d-spectrum antibiotics (including macrolides semisynthetic
icillins and cephalosporins), therefore it is important to
sider its diagnosis in patients who develop diarrhea in
ociation with the use of antibiotics Such colitis may range in
erity from mild to life-threatening
reatment with broad-spectrum antibiotics alters the normal
of the colon and may permit overgrowth of clostridia Studies
cate that a toxin produced by *Clostridium difficile* is one
ary cause of antibiotic-associated colitis
ild cases of pseudomembranous colitis usually respond to
discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g. pressor amines antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18 0.20 0.21, and 0.16 mcg/ml at two, three four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections including the prophylaxis of rheumatic fever See prescribing information

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WANTED: The Charles Drew Health Center in Omaha, NE is seeking a board certified/eligible family practitioner to fill the fulltime position of medical director. Competitive salary and fringe benefits. Send curriculum vita to: Robert L. Patterson, Executive Director, Charles Drew Health Center, Inc., 3012 Grant Street, Omaha, NE 68111.

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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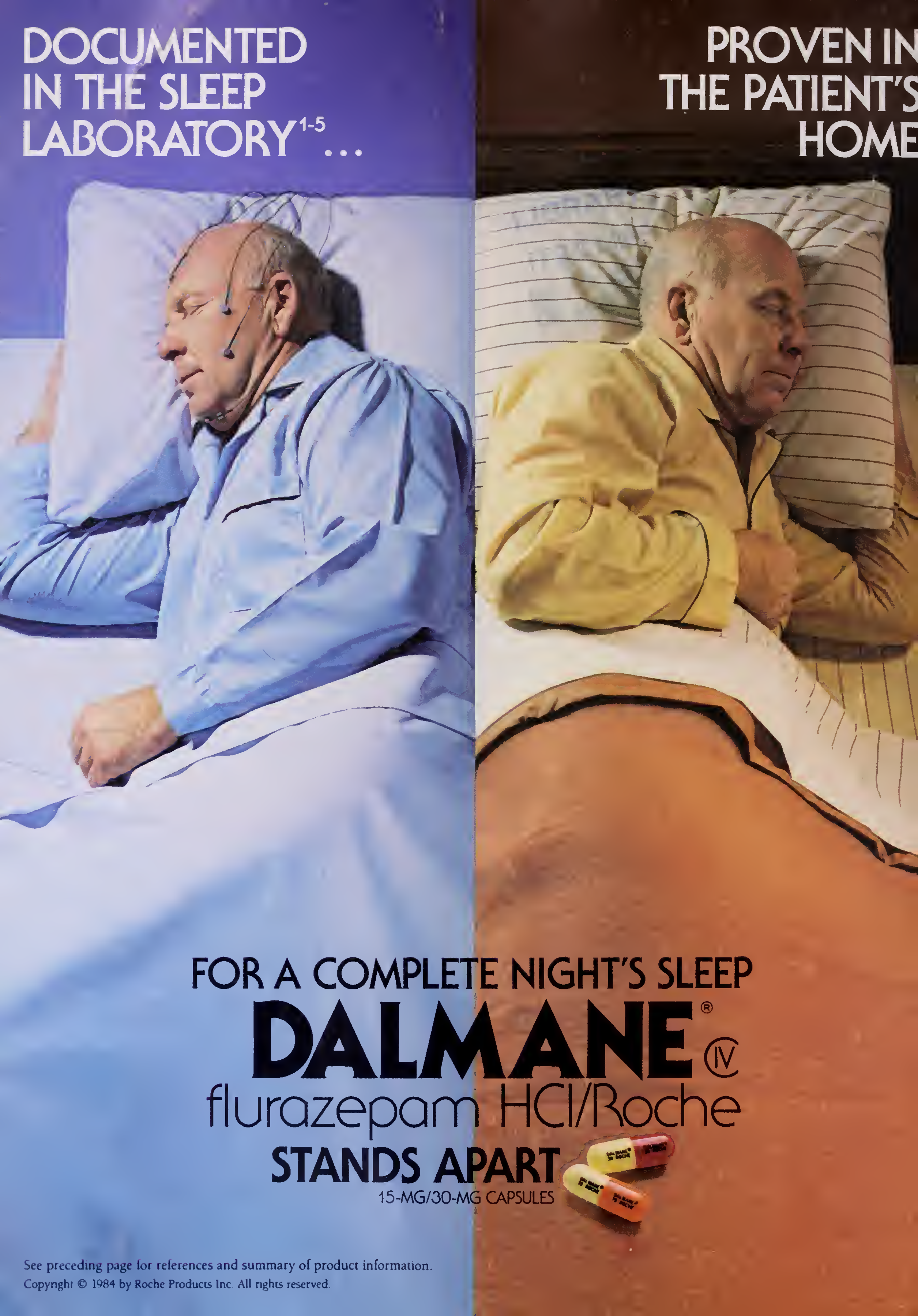

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THE NEBRASKA MEDICAL JOURNAL

117 Years

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WashingtoNotes

Capital Costs Considered Under PPS

Administration officials indicated in December that the fiscal 1986 budget may bring capital costs into Medicare's prospective pricing plan.

When it moved Medicare from cost-based payments to a prospective pricing plan based on diagnosis-related groups (DRGs), Congress left capital under the old cost-based system but required that it be brought into the DRG system by October 1, 1986. A report on how the Department of Health and Human Services proposed to do this was due to Congress last November, but the report is late.

The capital proposal, which may become a part of the budget proposal, reportedly is likely to add about 7% to each of the 468 DRGs to cover Medicare's share of hospitals' capital expenditures. Although existing capital spending commitments probably will not be exempted from the plan, the provision may include a transitional plan to alleviate the impact of the proposal on hospitals in the middle of expensive building or renovation.

Meanwhile, Sens. David Durenberger (R-MN) Chairman of the Senate Finance Committee and Robert Dole (R-KS), the new Senate Majority Leader, have written HHS Secretary Margaret Heckler to ask why the capital report has not been issued.

Durenberger also has proposed a block grant to replace Medicare's pass-through of the direct costs of medical education. The Administration supports this approach and is said to be working with Durenberger to design a single block grant to include the Medicare payment for medical education along with the Public Health Service's health professions education assistance program. This proposal also may be part of the 1986 budget proposal.

* * *

ANNOUNCING

117th Annual Session, Nebraska Medical Association

April 26-29, 1985

NEBRASKA ALLERGY SOCIETY

The objective of this course is to review current controversies regarding the treatment of asthma. This will include the use of theophylline and metaproteranol.

NEBRASKA SOCIETY OF ANESTHESIOLOGISTS

This program will present a clinical update on two diverse clinical subjects, anesthesia for trauma and obstetrics. A presentation on professional liability will provide a non-clinical balance and should be of interest to all.

AMERICAN CANCER SOCIETY

This course will present the most common cancer in the State of Nebraska, colo-rectal cancer. The objective of this course it to emphasize early detection and treatment of colo-rectal cancer, an effort which can return three out of four patients to normal active lives.

MISSOURI VALLEY DERMATOLOGIC SOCIETY

This course is divided into two sections, the first presenting common dermatologic conditions seen in general clinical practice. The second section will deal with specific skin problems seen in a pediatric patient population focusing on eczema, congenital lesions, and acne, including the use of Accutane.

NEBRASKA HEART ASSOCIATION LINCOLN DIVISION, and the NEBRASKA CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

This course is designed to review both cardiac and pacemaker arrythmias with emphasis on diagnosis and treatment. In addition, cost effective evaluation of dysrhythmias as well as pacemaker indications will be presented. There will be discussion on pharmacologic agents as well as drug inter-actions. This course is aimed at both primary care and subspecialty physicians who deal with cardiac patients.

NEBRASKA ACADEMY OF OPHTHALMOLOGY

The general topic of this course will be Strabismus. The speaker will be William E. Scott, M.D., Professor of Ophthalmology, Department of Ophthalmology, University of Iowa Hospitals and Clinics, Iowa City, IA.

NEBRASKA ACADEMY OF OTOLARYNGOLOGY

The title of the program will be "Management of Cancer in the Neck." This course will cover the management of metastatic squamous carcinoma of the neck, including N_0 neck. Different modalities of cervical lymph node dissection will be discussed, including the indications and technique of the functional neck dissection.

NEBRASKA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

The objective of this course is to update the primary care physician in areas of adolescent medicine.

NEBRASKA PERINATAL ORGANIZATION

The Nebraska Perinatal Organization will present speakers covering such topics as outcomes of the very low birth weight infants, neonatal seizures, the frustrated perinatal nurse, use of antibiotics in premature labor, home phototherapy, and stillborns in Nebraska.

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This course is designed to present topics of current interest to practicing radiologists.

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This course is designed for Candidates and Fellows of the American College of Surgeons to act as a forum for presentation of papers of current interest.

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The Auxiliary-sponsored portions of the Annual Session will include its Annual Board Meeting on Friday morning, a progressive dinner Friday evening, the brunch and presentation of awards Saturday morning, a meeting of the Gavel Club Friday afternoon, and the meeting of the new Board on Sunday.

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116th Annual Session

April 26-29, 1985

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Lincoln, Nebraska

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WashingtoNotes

Durenberger Said to Doubt DRGs for Physicians

Sen. David Durenberger (R-MN), who heads the Senate Finance Health Subcommittee, reportedly is having doubts about plans to include physicians in a prospective pricing scheme based on diagnosis.

Durenberger, whose influence on health policy is expected to expand as a result of changes in Senate Republican leadership, had previously said he favored the inclusion of a physician payment in each of the hospital DRGs.

Recently, however, Durenberger has said that while he still thinks physicians will have to be brought into a prospective system, he is not certain that DRGs are the best way to do this. That view has also been reiterated by Durenberger aide Chip Kahn.

Addressing a recent meeting of the American Health Planning Association and the National Health Lawyers Association, Kahn

Continued on page 12a)

Share An Evening With The President

at the annual Inaugural Banquet, 1985 Annual Session
Nebraska Medical Association
Cornhusker Hotel, Lincoln, Nebraska
April 28, 1985

"If We Don't Care, Who Does?"

Joseph F. Boyle, M.D.
President
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Dr. Boyle

Physicians and their spouses are urged to plan attendance at the Inaugural Banquet as one of the highlights of the 117th Annual Session. Dr. Frank D. Donahue will be installed by Dr. Herbert E. Reese to launch the new year for the Nebraska Medical Association.

Dr. Boyle is a veteran leader in the AMA who has also been highly honored for leadership in his specialties--internal medicine and diseases of the chest. His community and state-wide leadership from his home in Los Angeles, and ten years experience on the AMA Board of Trustees, provides him with an excellent base from which to speak with authority on the critical issues facing medicine today.

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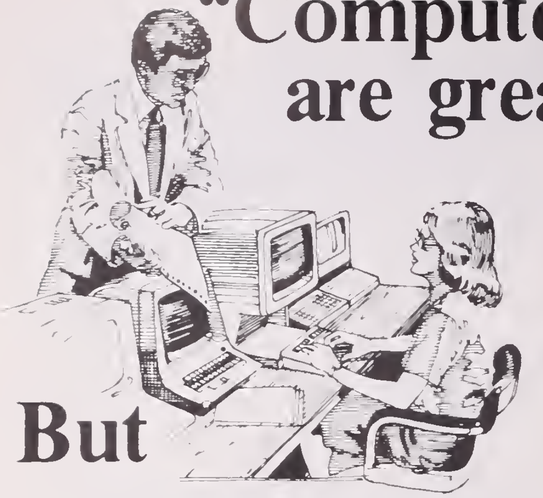

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WashingtoNotes

(Continued from page 6a)

said he thinks rushing into a DRG for physicians is a little frightening. He suggested that research on a physician DRG has had mixed results and expressed concern that a doctor DRG could change the physician-patient relationship. Senate staff will be very cautious on the issue of physician reimbursement changes and on inclusion of capital expenditures in DRGs, he predicted.

* * *

'Baby Doe' Draft Regulations Published

Once again tackling the issue of when to withhold treatment — and how to intervene when treatment is inappropriately withheld — the Department of Health and Human Services (HHS) in December published draft "Baby Doe" regulations to implement the new Child Abuse Prevention and Treatment Act amendments passed by Congress earlier this year.

The proposed regulations more narrowly define instances when treatment should be withheld than the broader language of the Act. According to the proposed regulations, care should be withheld only when:

* the infant is chronically and irreversibly comatose.

* treatment would not correct all of the infant's life-threatening conditions. (These are conditions that would significantly increase the "risk of the onset of complications that may threaten the life of the infant," HHS said.)

* treatment would merely prolong dying. (These are situations when "death is imminent," according to HHS, and would not include a more lingering death by diseases such as Tay-Sachs.)

* treatment would be virtually futile and inhumane, meaning that treatment is highly unlikely to prevent imminent death.

Additionally, the proposed regulations 'strongly recommend" the establishment of Infant Care Review Committee (ICRCS) in hospitals that care for infants, especially those with tertiary level neonatal care units. The

(Continued on page 20a)

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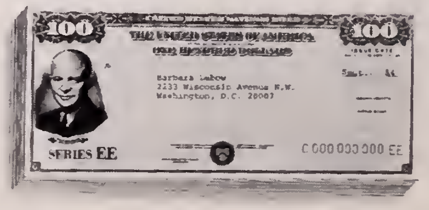

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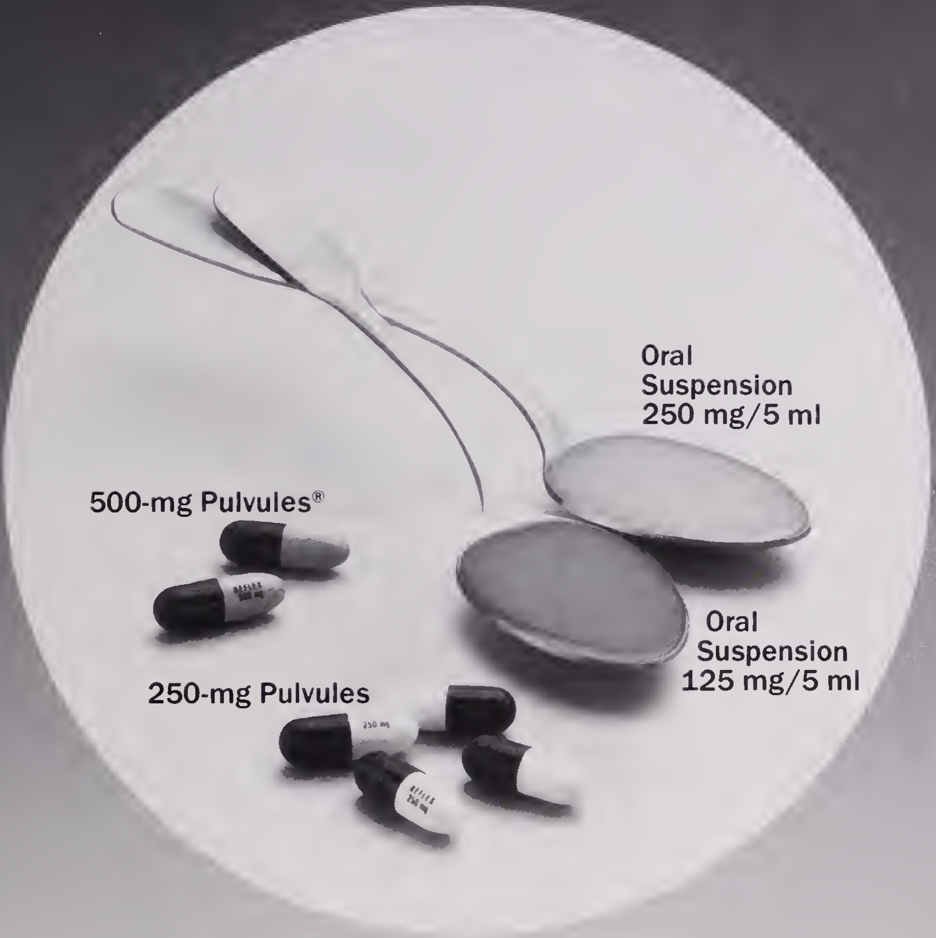

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Immanuel Medical Center

Announcing . . .

ONCOLOGY FELLOWSHIP PROGRAM — APRIL 11-12, 1985

A two-day continuing education program in Oncology for primary care physicians will be held at Holling Education Center, Immanuel Medical Center, April 11-12, 1985. This program is designed to enhance physician's diagnosis, treatment and follow-up skills in dealing with the most prevalent oncology diagnoses. Continuing Medical Education (CME) credits are offered for participation in the program.

Spouses are invited to participate in special activities; participants and faculty will enjoy an evening of elegant "dining out" together on Thursday, April 11. Participants are housed at the beautiful new Immanuel Plaza Motel on the Medical Center campus.

An agenda for the two-day program is as follows:

First Day

- Introduction to Cancer
  - John B. Davis, M.D.
- Principles and Treatment of Cancer:
  - Radiation Oncology
  - Chemotherapy
    - David J. Harter, M.D.
    - Herbert A. Hartman, Jr., M.D.
- Imaging Modalities
  - Paul Bender, M.D.*
  - W. Benton Copple, M.D.*
- Primary Oncologic Emergencies
  - John J. Hoesing, M.D.
- Colon Cancer Update
  - Mark Christensen, M.D.
- Tumor Markers
  - Thomas A. Ruma, M.D.
- The Black Spot - Malignant Melanoma
  - John F. Latenser, M.D.
- Lung Cancer Update
  - Leonard Moss, M.D.
  - David A. Hughes, M.D.
- The Role of the Family Physician in the Treatment of Cancer
  - Ronald C. Bell, M.D.
- Tour of Radiation Oncology

For more information on this or future Fellowships, contact Marion Kaple, Holling Education Center, Immanuel Medical Center, 6901 North 72nd Street, Omaha, Nebraska 68122, (402) 572-2340.

Second Day

- Tumor Conference
  - John B. Davis, M.D., Moderator
  - Panel — Medical Staff representing Hematology, Medical Oncology, Pathology, Gynecology, Surgery, Radiology, Urology, General Family Practice, Internal Medicine
- Gynecologic Tumor
  - Leon S. McGoogan, M.D.*
  - Terrence J. Kolbeck, M.D.*
- Chronic Lymphatic Leukemia
  - John R. Feagler, M.D.*
  - Joseph D. Verdirame, M.D.*
- Multiple Myeloma
  - John R. Feagler, M.D.*
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- Control of Pain in the Cancer Patient
  - David J. Harter, M.D.
- Skin Tumor, Diagnosis and Treatment
  - John F. Latenser, M.D.
- Breast Cancer Update
  - John B. Davis, M.D.
- Cancer Screening in the Physician's Office
  - William A. Shiffermiller, M.D.
- Prostatic Carcinoma
  - Stewart E. Sloan, M.D.*
  - Gerald C. Felt, M.D.*
- Liver Pumps and Hickman Catheters
  - Thomas Connors, M.D.
- Follow-Up of Cancer Patients
  - John B. Davis, M.D.

*Session presenter rotates for each Fellowship Program.

MEDICAL FELLOWSHIP PROGRAMS

Announcing . . .

CARDIOLOGY FELLOWSHIP PROGRAM APRIL 18-19, 1985

The Cardiology Fellowship to be held at the Holling Center on April 18-19, 1985, is a two day intensive program for primary care physicians. The program is designed to enhance diagnostic, treatment and follow-up skills in caring for the cardiac patient. Continuing Medical Education (CME) credits are offered for participation in the program.

Spouses are invited to participate in special activites: participants and faculty wil enjoy an evening of elegant "dining out" together on Thursday, April 18. Participants are housed at the beautiful new Immanuel Plaza Motel on the Medical Center campus.

First Day

Differential Diagnosis of Chest Pain
    Richard E. Collins, M.D.
Electrocardiography
    Richard E. Collins, M.D.
Treadmill Testing
    Steven J. Diamantis, M.D.
Current Therapy for Angina Pectoris
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Second Day

Bedside Exam of Cardiac Patient
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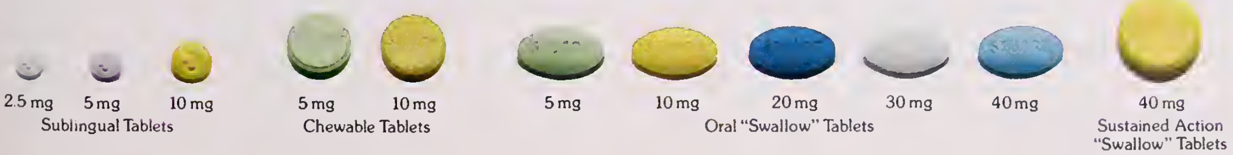

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See following page for brief summary of prescribing information.

SORBITRATE
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Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg) Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%) An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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WashingtoNotes

(Continued from page 12a)

committees could educate hospital personnel, recommend institutional policies, and offer counsel and review in Baby Doe cases, HHS stated.

The comment period will end February 8. Final regulations will be issued before March and states will have until October 9, 1985, to comply. Funding for the program, for such as medical consultations, will come from state child abuse grants.

The American Medical Association, which has successfully fought earlier Baby Doe regulations in the courts, immediately announced that it will use the public comment period to voice its continuing concerns regarding the amendments and the regulations.

"The Association continues to believe that the public does not agree with the goal of this legislation — which is to have government intrude into the right and responsibility of a mother and father to consult with physicians, clergy and other advisors and make a decision about the nature of their child's treatment," AMA Executive Vice President James H. Sammons, M.D., said. "The Association will continue to help protect the rights of families and to challenge the implementation of this legislation when it violates those rights."

Under the proposed regulations, Baby Doe cases will be treated like any other case of child abuse, with intervention by state authorities to prevent medical neglect. The state can pursue any legal remedy to prevent withholding of medically indicated treatment. Any investigation, however, must include coordination and consultation with a designated member of the hospital.

The proposed regulations are tied to the child abuse funds that the federal government dispenses to states each year; thus, any state willing to give up the funding would not be required to comply with the Baby Doe regulations. Last year, states received a total of $16.2 million — an average of $324,000 per state — to administer these child abuse programs.

(Continued on page 107)

THE NEBRASKA MEDICAL JOURNAL

A Quick Strep Test

HARLAN C. SHRINER, JR., M.D.
Lincoln, Nebraska

THE day of waiting one to two days for throat cultures taken for possible Group A strep infections may be over soon. In our office we have done 400 throat cultures during the past four months and processed them both with the Culturette brand 10-Minute Group A Strep ID (Marion Laboratories Inc., Kansas City, Mo.) and also plated them on our usual blood agar culture plates with the Bacitracin disc. A plate culture was designated positive with more than 100 colonies growth and at least 80% designated group A. Out of 400 tests done by both methods, the standard culture plate test revealed 238 positives and 162 negatives with the new Quick Strep Test revealing 233 positives and 167 negatives. So far in our hands the sensitivity of the new test is 97.9% and the specificity is 100%. The predictive value of positive was 100% and the predictive value of negative was 97%. In a recent article by Gerber et al,[1] their results revealed a sensitivity of 83% and specificity of 99%. The Culturette brand 10-Minute Group A Strep ID kit took approximately 10 to 12 minutes to run and cost in our office was less than $2.00 per test (this does not include paying for the technician's time).

Our lab technician, Stella Clark, states that this test is very easy to run, requires minimal equipment and that she feels very comfortable with the results obtained thus far. The four doctors in our clinic feel comfortable in treating or not treating a patient for Group A strep based on the outcome of the rapid test, but feel that we will continue to culture all of the rapid test negatives to be sure that we are not missing any false negatives.

Reference

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Percutaneous Balloon Valvuloplasty for Congenital Pulmonary Valve Stenosis

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PULMONARY valve stenosis is a common congenital cardiac malformation, ranking third in frequency of all cardiac defects in most reported series.[1] Until recently, the only available treatment for this condition was surgery to open or excise the stenotic valve. Although the most common surgical approach today is open pulmonary valvotomy with the patient on cardiopulmonary bypass, early approaches utilized closed techniques to dilate or cut the pulmonary valve and yielded excellent long term results.[2] The recent availability of large nondistensible polyethylene balloon dilation catheters has lead to the development of methods to perform percutaneous balloon pulmonary valvuloplasty, a catheterization technique analagous to a closed pulmonary valvotomy.[3] This procedure is performed in the catheterization laboratory without the necessity for general anesthesia or a thoracotomy. The purpose of this report is to describe the first three patients who have undergone percutaneous balloon pulmonary valvuloplasty at the University of Nebraska Medical Center.

PATIENTS

Case 1: This 5 year old female had clinical findings of pulmonary stenosis in infancy. She underwent cardiac catheterization at 1½ years of age to confirm the diagnosis and was found to have a maximal systolic pressure gradient of 30 mm Hg. At 5 years of age she underwent repeat cardiac catheterization because of progression of right ventricular hypertrophy on her electrocardiogram. The resting right ventricular systolic pressure had risen to 70 mm Hg. and right ventricular pressure increased to systemic levels following an angiogram. The pulmonary valve appeared thick, but not dysplastic, and there was post-stenotic dilation of the main pulmonary artery.

Case 2: This 6 year old female was followed since infancy for probable pulmonary stenosis. At 6 years of age, she underwent catheterization and was found to have severe pulmonary valve stenosis with resting right ventricular systolic pressure of 76 mm Hg. The right ventricular systolic pressure rose to suprasystemic levels following a right ventricular angiogram. The pulmonary valve was only slightly thickened.

Case 3: This 1½ year old little boy had a heart murmur detected shortly after birth. The clinical diagnosis of pulmonary stenosis was made after consultation by a cardiologist at 13 months of age. Subsequent cardiac catheterization revealed severe pulmonary valve stenosis with nearly systemic right ventricular pressure at rest and suprasystemic right ventricular pressure following a right ventricular angiogram. The pulmonary valve was moderately thickened but there was significant post-stenotic dilation of the main pulmonary artery.

BALLOON VALVULOPLASTY PROCEDURE

Catheterization data on these three patients were reviewed at the joint Pediatric Cardiology-Thoracic Surgery conference and they were felt to be good candidates for balloon valvuloplasty. Parents were offered the choice of conventional surgical pulmonary valvotomy or balloon valvuloplasty. The limited experience and lack of long term follow-up with the balloon valvuloplasty procedures was explained in detail. All parents offered the procedure chose balloon valvuloplasty over surgery.

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During each procedure, an operating room, cardiopulmonary bypass pump, and thoracic surgical team were immediately available and on stand-by. Two femoral venous catheters and a femoral arterial cannula were inserted percutaneously. One venous catheter was placed in the right ventricle for continuous monitoring and to serve as a site for intravenous drug administration. The second venous catheter was advanced to the pulmonary artery. Cardiac output was measured by thermodilution or Fick technique in each patient (in patient #2, oxygen consumption equipment malfunctioned during the procedure and assumed oxygen consumptions were used). A guide wire was then advanced through the pulmonary arterial catheter to the left pulmonary artery and the catheter was exchanged for a balloon angioplasty catheter. The balloon diameter used was slightly larger than the pulmonary valve annulus diameter as measured at the previous catheterization. (Table 1).

The balloon was carefully positioned and then inflated rapidly with dilute (15%) contrast material. Maximal inflation pressures ranged from 60-90 PSI. Inflations were done with continuous fluoroscopic observation and monitoring of femoral arterial and right ventricular pressures. If a "waist" (Figure 1) was not visualized during the inflation, the catheter was repositioned and the dilation procedure was repeated.

The right ventricular and pulmonary artery pressures were recorded after the heart rate returned to baseline. A right ventricular cineangiogram was then performed to re-evaluate the pulmonary valve morphology and to verify that there was no evidence of extravasation of dye.

RESULTS (Table 2)

Mean resting right ventricular systolic pressure decreased from 78.2 mm Hg. before the

Table 1

Pt.	Age (yrs.)	Weight (kg.)	Cath Size	Balloon Diameter (mm)	Annulus Diameter (mm)
1	5	17.1	9F	15	11
2	6	18.3	9F	18	16
3	1-1/2	13.3	8F	12	10

Patient data and balloon valvuloplasty catheter characteristics.

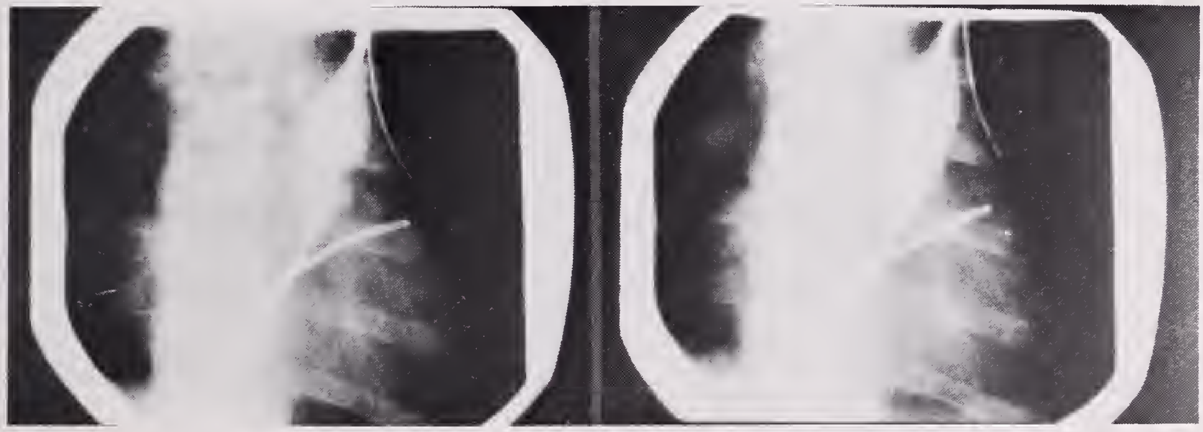

Figure 1

Cineangiographic frames obtained as the valvuloplasty balloon was inflated in patient 2. Early in the inflation (left frame) the stenotic pulmonary valve caused a "waist" in the balloon. As pressure in the balloon was increased, the constricted area suddenly expanded (right frame) indicating successful opening of the valve.

procedure to 43.3 mm Hg. following balloon valvuloplasty. Figure 2 is an example of the change in right ventricular pressure following valvuloplasty. The ratio of right ventricular systolic pressure to femoral arterial systolic pressure fell from .73 to .37. Mean peak systolic pressure gradient decreased from 62.7 to 26.7 mm Hg. Cardiac output tended to decrease slightly following the procedures.

In each case, the right ventricular pressure and peak systolic pressure gradient decreased to levels which obviated surgical intervention. Post-procedure angiograms demonstrated some increase in the diameter of the jet of contrast through the pulmonary valve, but it was not possible to accurately measure the diameter of the stenotic openings. Doppler echocardiography demonstrated trivial pulmonary insufficiency in patients 2 and 3 following the procedure but pulmonary insufficiency murmurs were not audible clinically.

There were no short or long term complications. Patients were awake and eating a regular diet within 4 hours of the procedure. All patients were monitored in the Pediatric Intensive Care Unit for 24 hours and remained an additional 24 hours in the hospital.

DISCUSSION

In 1979, Semb, et al reported a successful pulmonary balloon valvuloplasty in a neonate who was critically ill with pulmonary stenosis and massive tricuspid regurgitation.[4] In 1982, Kan and associates reported the first series of patients treated electively with this procedure.[3] Additional reports have confirmed the efficacy and safety of pulmonary valvuloplasty for acutely reducing right ventricular pressure and the pulmonary valve pressure gradient in both children and adults.[5, 6, 7]

Long term follow-up data on most valvuloplasty patients is not available since the procedure is new. Kan, et al, however, have reported catheterization date on 11 patients obtained 2-12 months (mean 7 months) following the procedure.[7] Right ventricular pressure and pulmonary systolic pressure gradient showed no significant change between the initial procedure and follow-up catheterization in the group of patients with typical pulmonary valve stenosis. There was one patient with a nodular, dysplastic pulmonary valve and no post-stenotic dilation of the pulmonary artery who had initial improvement in right ventricular pressure following two valvuloplasty procedures. However, on both occasions, follow-up studies showed worsening of the stenosis within several months. Patients with a dysplastic pulmonary valve, therefore, are probably not good candidates for balloon valvuloplasty. This is not surprising since it has been found that most such patients require pulmonary valve resection rather than simple valvotomy at the time of surgery.[8]

SUMMARY

More long term follow-up is necessary before balloon pulmonary valvuloplasty can completely replace open heart surgery in the

Table 2

Pt.	RV systolic Pressure		RV/FA Systolic Pressure		Peak Systolic Pressure Gradient		Cardiac Index	
	Pre-	Post-	Pre-	Post-	Pre-	Post-	Pre-	Post-
1	70	50	.60	.36	47	22	7.3	5.9
2	76	25	.69	.23	51	18	---	---
3	90	55	.90	.52	90	40	3.0	2.6
Mean	78.2	43.3	.73	.37	62.7	26.7		
St. Dev.	±10.7	±16.1	±.16	±.14	±23.8	±11.7		

Resting right ventricular (RV) systolic pressure, the ratio of RV to femoral artery (FA) systolic pressure, resting peak systolic pressure gradient across the pulmonary valve, and cardiac index (L/min/M^2) pre- and post-pulmonary valvuloplasty.

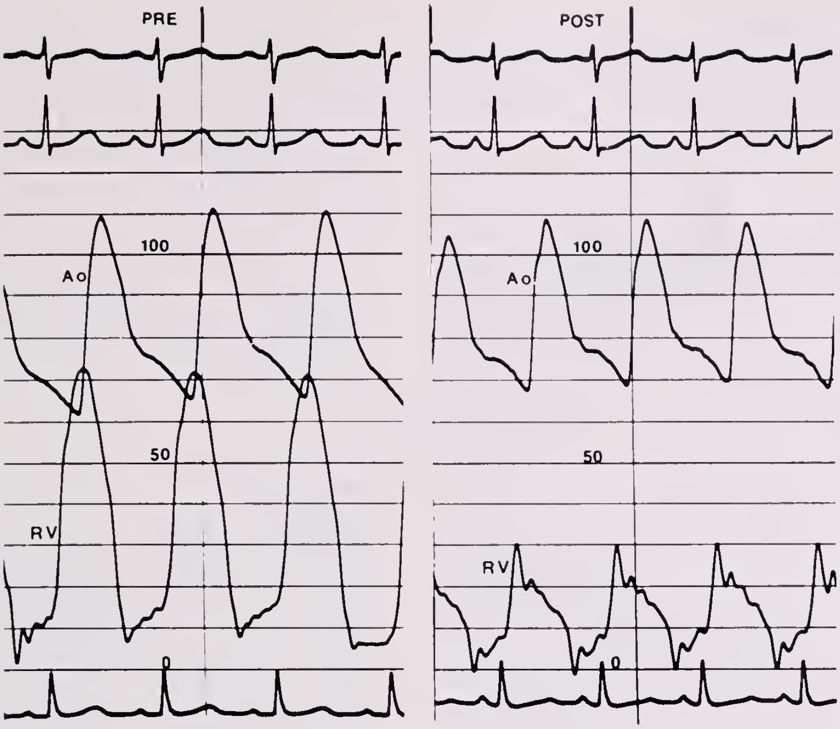

Figure 2
Aortic (Ao) and right ventricular (RV) pressure tracings from patient 2 PRE- and POST-balloon pulmonary valvuloplasty. There is little change in aortic pressure, but a marked decrease in right ventricular pressure to normal levels.

treatment of congenital pulmonary valve stenosis. However, balloon valvuloplasty can be performed with a low risk in experienced hands, and offers the advantages of reduced hospital stay, absence of a thoracotomy scar, and less patient discomfort compared to surgical valvotomy. Parents of our 3 patients were aware that there is little long-term follow-up data in valvuloplasty patients, but chose balloon valvuloplasty over surgical valvotomy primarily because of the lack of a surgical scar and shorter hospitalization. Repeat catheterization is planned for all of our balloon valvuloplasty patients in approximately one year (or sooner if there is clinical evidence of increasing pulmonary stenosis). If follow-up studies confirm that the effects of pulmonary valvuloplasty are long lasting, then this procedure may become the procedure of choice for all patients with pulmonary valve stenosis who do not have a dysplastic pulmonary valve.

Acknowledgement

The authors thank the staff of the Cardiac Catheterization Laboratory (Bob West, Lynn Rozler, Stacey Froemming, Jan Carr) for their technical support and Stephanie Goodrich for her secretarial assistance.

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The Non-Hodgkin's Lymphomas: A Review

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Classification

THE classification of the non-Hodgkin's lymphomas remains a controversial and confusing area. In 1956, Rappaport[1] classified the non-Hodgkin's lymphomas into nodular and diffuse groups based upon the lymph node architecture, and further divided each group into lymphocytic and histiocytic cell types according to the cytomorphologic appearance of the malignant cells. In 1974, Lukes and Collins[2] proposed their innovative immunomorphologic classification based upon their concept of lymphocyte transformation. Many other classifications have been proposed over the years, but the diverse terminology has only served to confuse the study of these lymphomas. Recently, a National Center Institute sponsored Working Formulation[3] was proposed to serve as a "means of translation among the various systems and to facilitate clinical comparisons of therapeutic trials." Undoubtedly, other classifications will appear in the future, but these three are the most important ones in clinical use at the present time. Each classification has its merits and none is clearly superior.

Under the new Working Formulation, non-Hodgkin's lymphomas are classified into low, intermediate and high grade groups. The low grade lymphomas are characterized by indolent growth and a favorable prognosis with a median survival of more than 6 years. Intermediate grade and high grade lymphomas have a much worse prognosis, 2.5 years and 1 year, respectively. Because of this, they are collectively referred to as poor risk, unfavorable or aggressive lymphomas. On the basis of these survival differences, the non-Hodgkin's lymphomas are commonly divided into two prognostic groups — low grade lymphomas and aggressive lymphomas.

Immunology of non-Hodgkin's lymphomas

Lukes' and Collins' concept of the normal lymphocyte response to antigenic challenge is schematically shown in Figure 1. When a small memory B cell is presented with antigen, blast transformation takes place in the germinal or follicular centers of the lymph node. The small B cell first develops a distinctive nuclear cleft and is termed a small cleaved lymphocyte (Stage I). The cell then becomes larger, but the nucleus remains clefted and the cytoplasm scanty. This cell is referred to as a large cleaved lymphocyte (Stage II). Later, when the nucleus becomes round and developes a prominent nucleolus, it is called a small noncleaved lymphocyte (Stage III). Finally, the cell becomes a large noncleaved lymphocyte with abundant cytoplasm (Stage IV). The transformed cell then exits from the follicle where it is identified as a B immunoblast in the interfollicular areas of the lymph node. It can either become a typical plasma cell or transform itself back into a memory B cell. T cells in the interfollicular areas of the lymph node undergo a transformation that is slightly different from that of the B cells and end up as T immunoblasts.

Lymphomas are malignancies of the immune system. As such, the malignant lymphocytes have normal lymphocyte counterparts in the lymph nodes from which they arise.[4] According to Lukes' and Collins' theory, malignant lymphomas arise from a maturation arrest at different stages of lymphocyte transformation.[2] Lymphomas of small lymphocytes, arrested at early stages of lymphocyte transformation, are characterized by indolent growth. Lymphomas of large lymphocytes, arising from fully transformed cells, have very aggressive growth characteristics.

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LOW GRADE LYMPHOMAS

The three histologic subgroups of the low grade lymphomas, according to Rappaport, Lukes - Collins, and the Working Formulation, along with their relative frequencies are shown in Table 1. The low grade lymphomas comprise approximately 40% of all the non-Hodgkin's lymphomas; two-thirds of them are nodular, poorly differentiated lymphocytic lymphoma, also known as follicular center cell lymphoma, small cleaved.

Table I

LOW GRADE LYMPHOMAS

Rappaport	Lukes-Collins	Working Formulation	% of all Low Grade Lymphomas	% of all non-Hodgkin's Lymphomas
Nodular poorly differentiated lymphocytic lymphoma (NPDL)	FCC*, small cleaved	Small cleaved cell, follicular	66	26
Nodular mixed lymphoma (NML)	FCC, small and large cleaved	Mixed small cleaved and large cell, follicular	23	9
Diffuse well differentiated lymphocytic lymphoma (WDLL)	Small lymphocytic Plasmacytoid lymphocytic	Small lymphocytic	11	4

°—According to the NCI sponsored Working Formulation series
*—Follicular Center Cell

Clinical Features

The median age at presentation is in the sixth decade. Patients usually present with painless lymphadenopathy, with or without hepatosplenomegaly. Extranodal presentations are unusual and occur less than 10% of the time. Less than 25% of patients have the classic constitutional symptoms of fever, weight loss or night sweats, although many patients will complain of malaise and easy fatigability.

The three most common causes of death are infections, progressive lymphoma and hemorrhage. Most patients die of bacterial infections, but opportunistic infections secondary to immunosuppression from the disease itself or its therapy also occur. Progressive lymphoma is the next most common cause of death. Each time a lymphoma relapses, remissions become harder to achieve and shorter in duration until finally the lymphoma is totally unresponsive to treatment. Hemorrhage usually results from thrombocytopenia resulting from either marrow replacement or chemotherapy-induced marrow suppression, but it can also result from tumor necrosis especially in the GI tract.

It is not uncommon for low grade lymphomas to evolve into more aggressive lymphomas when they relapse. In fact, more than 50% of all patients will transform their histology from low grade to aggressive some time in the course of their disease.[5,6] Therefore, patients who relapse with rapidly progressive adenopathy should be rebiopsied to rule out transformation to a more aggressive histology that would require more intensive treatment.

Staging

The Ann Arbor staging system,[7] designed for use in Hodgkin's disease, has been adapted for use in the non-Hodgkin's lymphomas and is shown in Table 2. Patients are clinically staged

Table 2

THE STAGES OF MALIGNANT LYMPHOMA

Stage I: Involvement of a single lymph node region or a single extralymphatic site

Stage II: Involvement limited to one side of the diaphragm either with two or more lymph node regions or localized extralymphatic involvement and one or more lymph node regions.

Stage III: Involvement of lymph node regions on both sides of the diaphragm which may include localized extralymphatic involvement.

Stage IV: Disseminated extralymphatic involvement.

A: Asymptomatic

B: If any of the following are present:
fever greater than 38° C
night sweats
weight loss greater than 10% of body weight in the preceding 6 months

by history and physical examination, laboratory and x-rays, and pathologically staged by tissue biopsy.

A thorough staging evaluation starts with a good history and physical examination. The physical exam should concentrate on the lymph nodes in the cervical, supraclavicular, axillary and inguinal areas, the liver and spleen and any abdominal masses which might represent retroperitoneal lymphadenopathy. The Waldeyer's ring area is normally rich in lymphoid tissue and should also be carefully examined. Although many patients will be found to have widespread disease by physical examination alone, laboratory and x-ray studies are important adjuncts especially in young patients who may be curable when their disease is localized.[8] Laboratory evaluation should include a CBC and chemistry profile. A chest x-ray will demonstrate hilar or mediastinal adenopathy. An abdominal CT scan or ultrasound is very helpful in evaluating retroperitoneal and mesenteric adenopathy. A bone marrow biopsy is done on all patients because of the high incidence of marrow involvement. After these staging procedures are performed, more than 90% of patients with low grade lymphomas will have Stage III or IV disease.[9]

Treatment

In general, low grade lymphomas are easy to control initially with greater than 75% of patients demonstrating reduction in the size of lymph nodes, liver and spleen with either chemotherapy or radiation therapy. The median survival of the low grade lymphomas is approximately 6.5 years, but as is schematically shown in Figure 2, these patients demonstrate a constant relapse rate with no evidence of a plateau on the survival curve, which implies little chance for cure of the disease.

Localized Stage I and II low grade lymphomas are treated with involved field radiation therapy. In a controlled trial, Rosenberg showed that local radiation therapy is as effective as more extensive irradiation.[10] Other studies have shown no additional benefit from adjuvant chemotherapy following radiation therapy.[11] The five year survival is excellent and is reported at 60% to 90%.[11] According to a recent report from Stanford, young patients less than 40 years old with localized Stage I and II low grade lymphoma may be curable when treated with radiation therapy.[8] These data await confirmation.

For the advanced Stage III and IV low grade lymphomas, the Stanford group has compared single agent chemotherapy with cyclophosphamide or chlorambucil to combination chemotherapy with cyclophosphamide, vincristine and prednisone (CVP), with and without total nodal irradiation[12] or whole body irradiation.[13] They found no difference in total survival, complete remission rate or duration of remission. Moreover, a more recent report from the same group has shown that when therapy is withheld until patients become symptomatic, survival is not adversely af-

Table 3

AGGRESSIVE LYMPHOMAS

Rappaport	Lukes-Collins	Working Formulation	% of all aggressive lymphomas°	% of all non-Hodgkin's lymphomas°
Diffuse histiocytic lymphoma (DHL)	FCC*, large cleaved & large noncleaved non-FCC, T & B cell immunoblastic sarcoma	Large cell, diffuse, cleaved & noncleaved Large cell, immunoblastic	50	31
Diffuse poorly differentiated lymphocytic lymphoma (DPDL)	FCC, small cleaved Convoluted lymphocyte	Small cleaved, diffuse Lymphoblastic	21	13
Diffuse mixed lymphoma (DML)	FCC or non-FCC, mixed small & large cell	Mixed small & large cell, diffuse	13	8
Diffuse undifferentiated lymphoma (DUL)	FCC, small noncleaved	Small noncleaved	10	6
Nodular histiocytic lymphoma (NHL)	FCC, large cell, follicular	Large cell, follicular	6	4

°—According to the NCI sponsored Working Formulation series
*—Follicular center cell

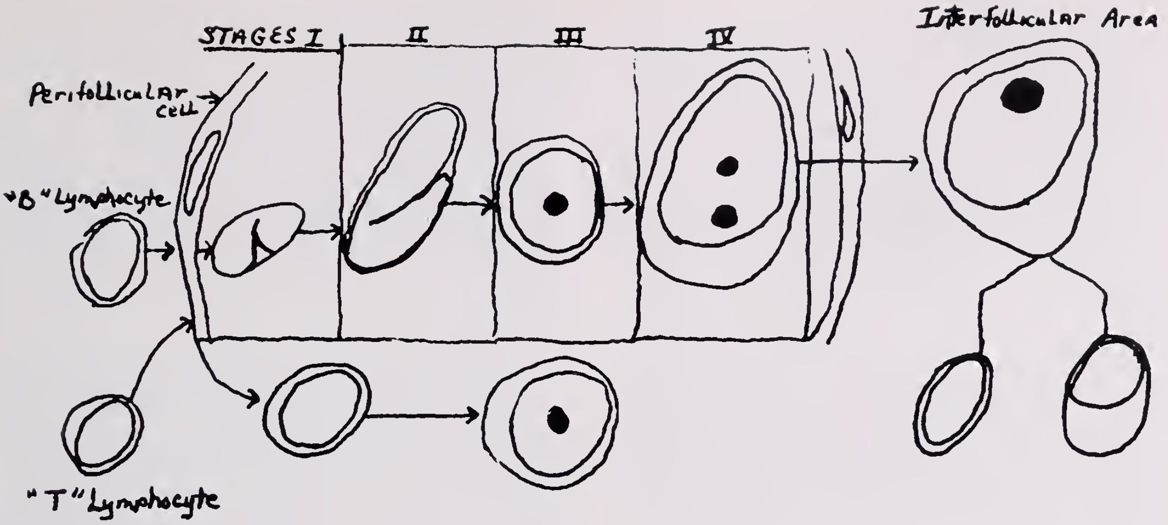

FIGURE 1: Schematic representation of normal lymphocyte transformation. Reproduced from Lukes RJ, and Collins RD. Cancer 34: 1488, 1974 with permission of the authors and editor.

fected.[14] These studies have fostered a conservative approach to the therapy of these patients. Whether the more intensive chemotherapy combinations currently used to treat aggressive lymphomas can improve survival in the low grade lymphomas remains to be seen.

Certain poor prognostic features can be identified in a small subset of patients who have a high mortality in the first two years following diagnosis despite their favorable histology: age greater than 65, constitutional symptoms (the B symptoms), extranodal presentation, and prior chemotherapy.[15] Patients with any of these poor prognostic features should be considered for more intensive treatment.

Since there are several treatment options available for patients with low grade lymphomas, the choice of therapy must be individualized. The following factors should be considered in choosing the best therapy for an individual patient. First, the histology of the lymphoma is important. There is some evidence that patients with nodular mixed lymphomas (Rappaport classification) may have prolonged disease free remissions when treated with aggressive chemotherapy.[16] Second, the presence of B symptoms calls for more intensive treatment. Third, the pace of the disease is important. If the disease is noted to progress rapidly, the patient should be treated aggressively because the biologic activity of the lymphoma can be great even though the histology appears indolent. Fourth, the site of the disease often dictates the need for therapy. For example, ureteral obstruction secondary to retroperitoneal adenopathy usually requires immediate radiation therapy. Lastly, elderly patients do poorly and may benefit from more aggressive treatment if their overall medical condition permits.

No matter what therapy is chosen, it is important to obtain a complete remission of the disease in order to have a significant chance of improving survival. Patients with either a partial remission or no response have a poor prognosis.[17]

AGGRESSIVE LYMPHOMAS

There are five histologic subgroups of aggressive lymphomas and they are listed with their relative frequencies in Table 3. Aggressive lymphomas comprise about 60% of all non-Hodgkin's lymphomas. The most common subgroup is diffuse histiocytic lymphoma, large cell cleaved and noncleaved, which accounts for 50% of these lymphomas.

Clinical Features

The median age at presentation is somewhat younger than in the low grade lymphomas and overall is approximately 50 years. Patients usually present with painless adenopathy but rapidly growing nodal and extranodal masses may cause pain. Forty-five percent of patients with aggressive lymphomas have constitutional symptoms of fever, weight loss or night sweats. Thirty to 40% present in extranodal locations such as the GI tract, head and neck, bone, skin and brain. Paradoxically, one-third present with localized disease, Stage I or II. As in the low grade lymphomas, most patients die of progressive lymphoma, infection or hemorrhage.

Staging

The staging evaluation once again starts with a good history and physical examination. A CBC is important because bone marrow involvement may result in cytopenias. A chemistry profile will evaluate liver and renal function as well as detect hypercalcemia or hyperuricemia, which are more common in aggressive lymphomas than in low grade lymphomas. Elevated LDH levels can be used as a marker of tumor bulk and disease activity. A chest x-ray is important to evaluate the mediastinum and hilar areas, and a lymphangiogram and CT scan of the abdomen are helpful in evaluating disease below the diaphragm. Aggressive lymphomas have a significant incidence of GI tract and bone involvement. However, GI series and bone scans are generally not indicated unless patients have symptoms which localize a problem to those areas. A bone marrow biopsy is done on all patients. A liver biopsy may be indicated if liver involvement would change a patient's therapy. Laparotomy is rarely needed. However, if a patient has clinical Stage I disease and it is planned to treat him with curative radiation therapy alone, laparotomy may be indicated because 10% of these patients have intraabdominal disease discovered at laparotomy.[9]

Treatment

It is paradoxical that patients with aggressive lymphomas can achieve prolonged disease-free survival which is tantamount to cure,[18] whereas patients with low grade lymphomas are rarely cured (see Figure 2). Since only patients who obtain a complete remission have any chance for long term survival,[19] initial aggressive therapy is indicated.

The long term survival rate with radiation therapy alone for pathologic Stage I disease is approximately 90%.[20] However, when patients with Stage II disease are treated with radiation alone, 70% will relapse.[20] Chemotherapy is also very effective in localized Stage I and II disease. The long term survival rate for Stage I patients treated with chemotherapy is 100% and for Stage II patients is 90%.[21] Therefore, for Stage I disease, therapy can be with either chemotherapy or radiation therapy, but for

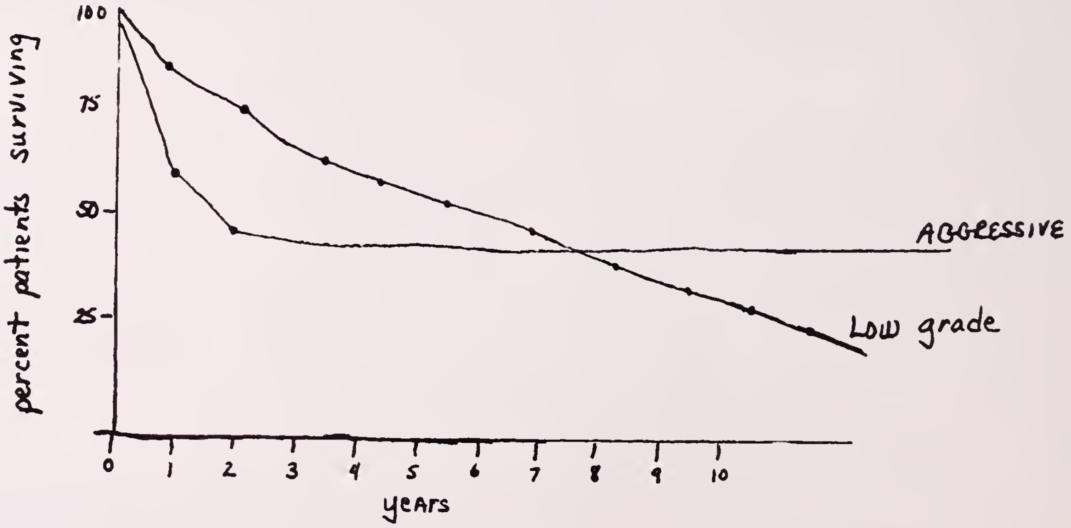

Figure 2
Schematic Representation of Survival Curves for the Low Grade and Aggressive Lymphomas

Stage II disease the preferred treatment is chemotherapy.

It is in the treatment of Stage III and IV aggressive lymphoma that significant advances have been made. Unlike the treatment of low grade lymphomas, single agent chemotherapy is ineffective and combination chemotherapy must be used. First generation chemotherapy consisted of cyclophosphamide, vincristine and prednisone (CVP). This yielded a complete remission rate of 30% to 40% and a cure rate of approximately 10%.[22] Second generation chemotherapy regimens included C-MOPP[18] (cyclophosphamide, vincristine, prednisone and procarbazine), CHOP[23] (cyclophosphamide, adriamycin, vincristine and prednisone), BACOP[24] (CHOP plus bleomycin) and COMLA[25] (cyclophosphamide, vincristine, methotrexate with leucovorin rescue and cytosine arabinoside). With these regimens, the complete remission rate increased to 40% to 55% and long term survival improved to 30% to 40%. It should be pointed out, however, that CHOP, the most widely used regimen, appears to have the poorest long term survival rate (only 25%) of any of these regimens.

Table 4

POOR PROGNOSTIC FEATURES IN AGGRESSIVE LYMPHOMAS

1. Male sex
2. Age greater than 65
3. T cell or null cell type
4. Advanced stage
5. B symptoms
6. Bulky abdominal masses greater than 10 cm. with GI tract involvement
7. Bone marrow involvement
8. Liver, mediastinal, or CNS involvement
9. LDH greater than 250 U/dl
10. Hemoglobin less than 12 gm/dl
11. Prior chemotherapy

Many investigators have analyzed the clinical features associated with a poor response to therapy and a poor survival. These poor prognostic features are listed in Table 4. Using a multivariate analysis, the four worst prognostic factors are male sex, B symptoms, bulky abdominal masses with GI tract involvement, and bone marrow involvement.[26]

In the last four years, a third generation of chemotherapy regimens has been developed. Three new regimens termed M-BACOD,[27] (methotrexate with leucovorin rescue, bleomycin, adriamycin, cyclophosphamide, vincristine and dexamethasone), ProMACE-MOPP,[19] (prednisone, methotrexate with leucovorin rescue, adriamycin, cyclophosphamide and etoposide - nitrogen mustard, vincristine, prednisone and procarbazine), and COP-BLAM,[28] (cyclophosphamide, vincristine, prednisone, bleomycin, adriamycin and procarbazine), have been reported to yield a higher complete remission rate of 70% to 75% as well as a higher cure rate of 60% to 65%. More importantly, these new regimens appear to be just as effective for those patients who have poor prognostic features as they are for patients without these features.

Table 5

CAUSES OF TREATMENT FAILURE IN AGGRESSIVE LYMPHOMAS

1. Failure to achieve a complete remission
2. Systemic relapse
3. CNS relapse
4. Drug-related toxicity
5. Second malignancies

The causes of treatment failure and ultimate death are listed in Table 5. Twenty to 25% of patients will never achieve a complete remission. Fifteen to 20% of the complete responders will have systemic relapse, usually within two years of completing therapy. Fewer than 5% will have central nervous system relapse with these newer regimens but 5% to 10% will develop life-threatening sepsis due to chemotherapy-induced granulocytopenia which is the most serious complication of aggressive combination chemotherapy. Second malignancies are currently not a clinical problem but as treatment becomes more intense with chemotherapy or combined chemotherapy and radiation therapy, second malignancies may become more common, analogous to the increased incidence of second malignancies in patients with Hodgkin's disease treated with combined modality therapy.

Summary

The non-Hodgkin's lymphomas can be divided into two prognostic groups — low grade and aggressive lymphomas. The low grade lymphomas are characterized by widespread disease at presentation, lack of constitutional symptoms, an indolent growth pattern, response to nonaggressive radiation or chemotherapy, and a median survival of more than 6 years. Despite all this, these lymphomas are incurable. The aggressive lymphomas, in contrast, are characterized by a high incidence of constitutional symptoms and extranodal presentation, exhibit rapid growth, require intensive chemotherapy and have a median survival of only 1.5 years. Paradoxically, however, these lymphomas are curable for a high percentage of patients who achieve a complete remission with appropriate therapy.

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Correlation of Electrocardiographic Changes with Plasma Quinidine Concentration

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QUINIDINE is a commonly used oral antiarrhythmic agent. Because of its low therapeutic index, dosing is frequently guided by plasma quinidine concentrations (QC). It is well known that quinidine affects cardiac conduction and repolarization, manifested electrocardiographically by prolongation of both QRS and QT duration.[1-3] Several authors[1,4,5] have suggested that QT prolongatoin correlates with antiarrhythmic effect, whereas QRS widening is a late toxic manifestation of the drug. Using a non-specific quinidine assay, Heissenbuttel and Bigger[2] demonstrated a direct correlation between QRS duration and therapeutic QC.

Improvement in analytical methods have led to specific quinidine assays. The high-pressure liquid chromatography (HPLC) assay is a specific quinidine assay which determines QC without measuring the metabolites and impurities of the drug.[6] According to LeRoyer,[7] the HPLC method is the most efficient, specific and sensitive assay for quinidine.

Because the HPLC assay has a lower stated therapeutic range than older non-specific assays,[8] an evaluation of the relationship between HPLC-derived QC and drug induced electrocardiographic changes is warranted. If a strong correlation is found, this could have clinical application since electrocardiography is more widely available than plasma quinidine assays. Therefore, we prospectively evaluated the correlation of ECG changes to HPLC-derived QC.

Methods

Patients, 18 years of age or older, admitted to University Hospital for control of either atrial fibrillation and/or frequent ventricular premature depolarization (≥ 30/hour), were invited to participate. Patients receiving drugs which may affect the QRS and QT intervals (procainamide, disopyramide, phenytoin, verapamil, tricyclic antidepressants and phenothiazines) and patients with long QT syndromes were excluded. The protocol was approved by the Institutional Review Board; informed consent was obtained from all participants. Baseline twelve-lead electrocardiogram (ECG), 24 Hour Holter monitor, serum electrolytes, blood urea nitrogen, serum creatinine, SGOT and total bilirubin were obtained before the start of quinidine therapy.

Each subject received 10-14 mg/kg/day of quinidine base given orally as either the sulfate or gluconate salt every six to eight hours. Six-lead ECG's (I, II, III, aVR, aVL, aVF), and blood samples (drawn two hours after the oral dose of quinidine sulfate and four hours after the oral dose of quinidine gluconate) were obtained twice on days one and two and once on the third day after the start of quinidine therapy. The ECG's were recorded on a single-channel electrocardiograph (Automatic Cardiograph 1515B; Hewlett-Packard, Corvalles, OR 97330). To enhance the horizontal amplification of the ECG parameters, the electrocardiograms were recorded at a paper speed of 50mm/sec. The QRS and QT interval were measured to the nearest one-half millimeter (0.5mm = 5msec). This technique allowed a sensitivity of measurement of ± 5 msec which is feasible on all standard electrocardiographs. Using the ECG lead yielding the widest QRS complex, two observers who were blinded to the plasma quinidine level each made five measurements of QRS duration. These ten measurements were averaged. The same procedure was repeated for the QT interval using Bazzett's formula[9] ($QT_C = QT/\sqrt{R\text{-}R}$) to correct for heart rate.

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The blood samples were drawn through intravenous heparinized catheters. The initial 2 ml of blood from each subject were discarded, then 7 ml of blood were collected in tubes containing sodium fluoride and potassium oxalate. The samples were centrifuged immediately and the plasma was frozen in silanized teflon-capped culture tubes. Plasma quinidine determinations were performed in the Clinical Toxicology Laboratory using the high pressure liquid chromatography method described by Bridges et al.,[6] which is specific for quinidine and does not measure the metabolites and impurities of the drug. This assay had a sensitivity limit of 0.5 mcg/ml and a coefficient of variation for identical samples of less than four percent.

Data Analysis

The changes in the QRS complex and the QT interval from control values (Δ QRS and Δ QT) and the plasma quinidine concentration (mcg/ml) were plotted on a scattergram. A least-squares line of best fit was obtained by regression analysis to determine if the dependent variables changed as a function of the independent variable.[10] Student's t-test was used to evaluate the significance of the slope of the regression line. Linear calibration analysis was used to plot the predicted plasma quinidine concentration at a given change in the ECG parameters.[11] Patient data are represented as the mean ±1 standard deviation (X ± SD).

Results

Four subjects, ages 66 to 80 years (mean = 71), were enrolled. Arrhythmias included premature ventricular complexes in three and atrial fibrillation in one. The baseline QRS measurement for the group was 77 ± 21 msec. The baseline QT_C measurement for the group was 411 ± 18 msec. All subjects had normal serum electrolytes, blood urea nitrogen, serum creatinine, SGOT and total bilirubin.

A total of 20 paired six-lead electrocardiograms and blood samples were obtained from the four subjects. Three blood samples had to be discarded because they were severely hemolyzed. Seventeen paired six-lead electrocardiograms and blood samples were included in the data analysis. The average serum quinidine concentration for the group was 2.8 ± 1.5 mcg/ml. The widest QRS measurement averaged 110 ± 23 msec and the longest QT_C interval averaged 484 ± 62 msec. The mean change from baseline in the QRS complex was 25 ± 13 msec; the mean change from baseline in the QT_C interval was 57 ± 50 msec.

The ECG measurements (Δ QRS and $\Delta\ QT_C$) were plotted as a function of the simultaneous QC (Figure 1). The Pearson product moment correlation coefficient revealed a linear relationship ($p < 0.01$) between the changes in the dependent variables and the QC with a coefficient of determination of 0.38. The regression line for Δ QRS versus QC is described by the equation $\Delta\ QRS = 5.18 \cdot QC + 10.9$. The equation for the regression line of $\Delta\ QT_C$ versus QC is $\Delta\ QT_C = 20.41 \cdot QC + 0.51$. The slopes of the two regression lines were different from zero ($p < 0.01$).

The linear calibration graphs (Figure 2) showed that QC can be reliably predicted ($p < 0.01$) from a given Δ QRS or Δ QT value.

Discussion

The most prominent electrocardiographic effect of quinidine at therapeutic plasma concentrations appears to be prolongation of the QT interval without widening of the QRS complex.[1,5] Widening of the QRS complex has been considered a late effect seen when high plasma concentrations of quinidine are achieved. Heissenbuttel and Bigger[2] have suggested that failure to recognize QRS widening at low quinidine concentrations might be due to an inability to discern the small changes that occur in the width of the QRS complex when measured on the standard electrocardiogram. Using a time-expanded oscilloscope display to enhance horizontal amplification of the ECG complexes, these authors found that quinidine significantly prolonged the duration of the QRS complex at plasma concentrations as low as 2 mcg/ml. Significant changes in both the QRS complex and the rate-corrected QT interval correlated with plasma quinidine determinations within the range of 2 to 5 mcg/ml determined by non-specific fluoro-

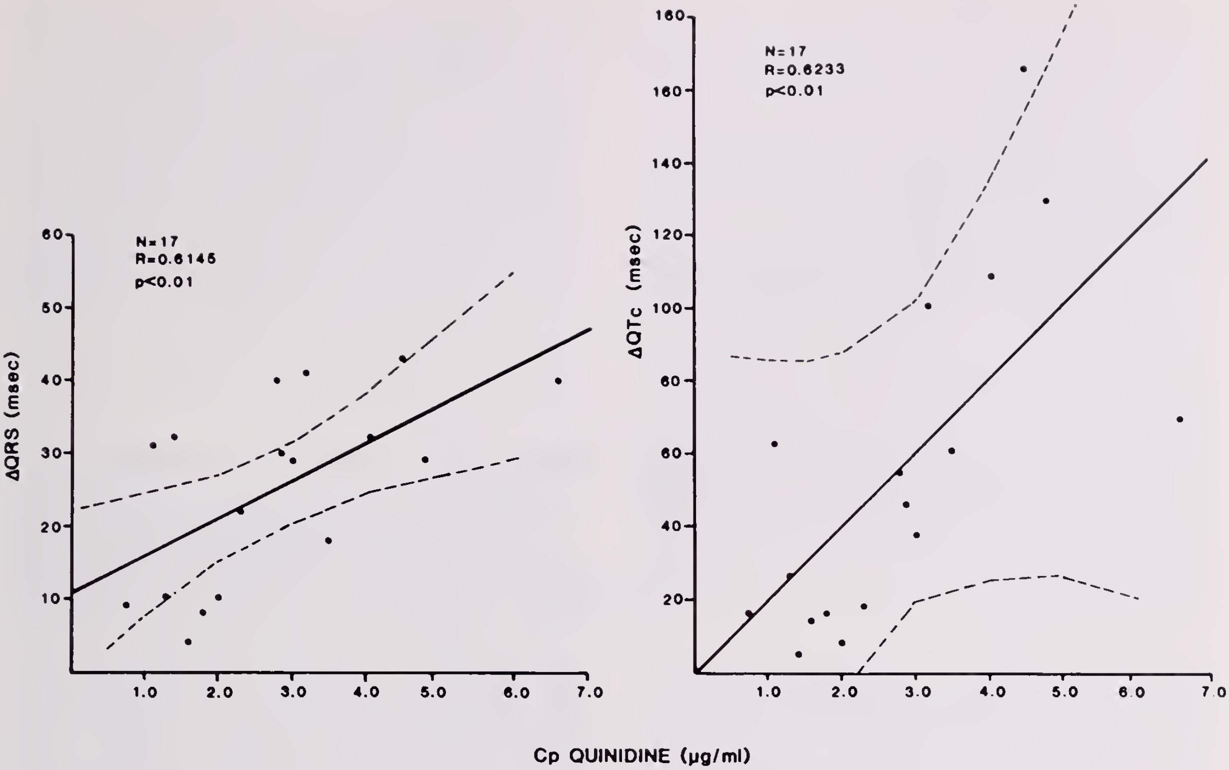

Figure 1

Relationship between changes in QRS and QTc intervals from control values and plasma quinidine concentration (Cp Quinidine). The calculated regression line and the 95 percent prediction interval (broken line) are shown.

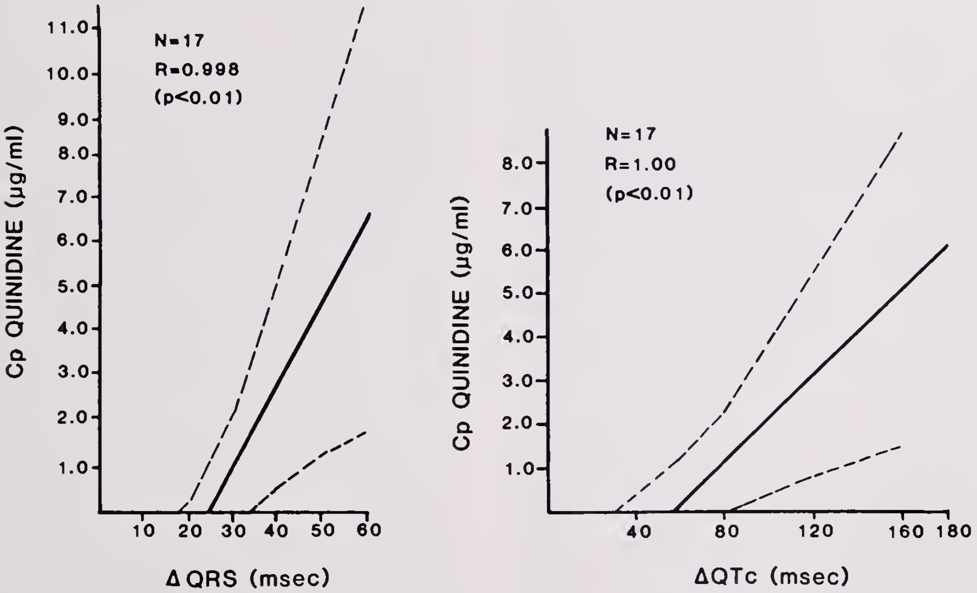

Figure 2.

Predicted plasma quinidine concentration (Cp Quinidine) for a given change in the QRS or QTc intervals. The calibration line and the 95 percent prediction level (broken line) are shown.

metric assay.[2] Using an HPLC assay, Holford and co-workers[3] administered single doses of quinidine to ten normal volunteers. A significant correlation between the QT interval and QC was found within the range of 1 to 3 mcg/ml while no correlation was apparent with QRS duration.

We used the HPLC assay and high speed ECG recording to improve sensitivity. Linear regression analysis revealed a significant correlation between both ECG parameters and QC; the QRS and QT_c interval changed as a function of the QC within the range of 1.1 to 4.8 mcg/ml. Our results agree with the findings of Heissenbuttel and Bigger[2] and may reflect the more precise ECG methods used. Unlike the method used by Heissenbuttel and Bigger, our technique is feasible on all standard electrocardiographs.

The lower range of plasma concentrations reported in this study compared to results of other studies can be explained by differences in the assay methods. The non-specific assays used by previous workers do not adequately separate quinidine from its impurities and polar metabolites. A 20-50 percent increase in concentration above the "true" quinidine concentration has been reported when non-specific assays are compared to an HPLC assay similar to that used in the present study.[12]

Previous authors have suggested that QT prolongation occurs at a lower QC than does QRS prolongation.[1,5] Although our study did not specifically address this, we compared the QC's which produced the maximum QRS and QT widening in our subjects and found no significant differences. These findings are consistent with the data of Heissenbuttel and Bigger[2] and may reflect the similar method employed in measuring ECG changes. It appears that, when sensitive methods are used, the effects of quinidine on QRS and QT duration are similar.

An electrocardiogram is usually more readily available and less expensive to perform than a quinidine assay. In order to provide a non-invasive method for monitoring quinidine therapy, we examined the ability of the ECG parameters to predict the QC. The coefficient of determination revealed that 38% of the variance in both the Δ QRS and Δ QT_c could be explained by the QC. Linear calibration analysis revealed a strong correlation between the estimated QC and both the Δ QRS and Δ QT_c. For Δ QRS, the 95% confidence interval about the calibration line indicated that a 20 to 50 msec change reflected a QC within the range of 1.1 to 4.8 mcg/ml. Similar results were observed in QT_c, where a 60 to 120 msec change reflected a similar QC range. Therefore, the utility of the QRS complex QT_c interval in assessing therapeutic response and potential toxicity deserves further study.

Conclusion

In this preliminary study in 4 patients, we have demonstrated a linear correlation between the ECG changes of QRS and QT duration and HPLC-derived QC, and have shown that these ECG changes may serve to predict the QC. A study with a larger sample size could improve the reliability of the derived regression equations and possibly verify the usefulness of the ECG in predicing QC. These findings could have an impact on patient care. In rural areas where quinidine levels are less readily available, the ECG could serve as a reliable and inexpensive method for monitoring quinidine therapy. Overall, the cost of antiarrhythmic therapy would decrease by reducing the number of drug levels ordered.

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Sudden Infant Death Syndrome — A Six-Year Family Follow-up in Nebraska

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THE Sudden Infant Death Syndrome (SIDS) is defined as the "sudden, unexpected death of an apparently healthy infant for whom a thorough autopsy fails to identify the cause of death."[1] SIDS is the largest single cause of death in the post neonatal period. The incidence ranges from 2-3 per 1,000 live births in urban western countries with a mean figure of 2.5.[2] Recent studies have reported in the United States an overall risk of 2 cases per 1,000 live births.[3] While research has escalated enormously in the past 10 years, the final etiology of SIDS remains an enigma although current research indicates that SIDS victims are not normal anatomically or physiologically. During this period of time, apnea of infancy was defined as: "an unexplained and frightening episode of cessation of breathing for 20 seconds or longer, or a shorter respiratory pause associated with bradycardia or cyanosis or pallor."[4] The "near-miss" infant is defined as an infant who ceases to breathe and requires stimulation or resuscitation for resumption of spontaneous breathing. The term "near-miss SIDS", as defined by Shannon, et al, diagnostically imprecise on the one hand and prognostically prejudicial on the other, best describes our current state of ignorance while calling the physician's attention to the high-risk infants.[5] Once respiratory, cardiac, and neurologic origins of apnea, cyanosis, and pallor are eliminated, there are a number of infants in whom no abnormalities are found. These definitions, coupled with the development of home monitoring equipment,[4] has markedly changed the management of these infants. Subsequently, home monitoring is being increasingly adopted by physicians, along with parental concerns for prevention, particularly with subsequent siblings of a SIDS victim. Anxiety and fear of a recurrence are major problems for parents. Southall reviewed the literature on siblings of SIDS victims, consisting of 5 studies. This revealed that only one of 459 siblings, including 72 monitored, subseqently died and that infant had experienced an episode of apnea.[6] However, Froggat, et al, and Peterson, et al, reported that there is an increased risk to subsequent siblings up to 20/1,000.[7-8] Many other studies evaluating SIDS siblings have reported interesting and provocative relationships, but it is debatable whether this research approach has yet to produce solid scientific data. Nevertheless,

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until proven otherwise, SIDS siblings are categorized as high risk for SIDS.

Since August, 1983, the indications for apnea monitoring and pneumograms in Nebraska are: 1) Siblings of SIDS; 2) Near-miss SIDS; 3) Twins of SIDS victims; 4) Premature babies; 5) Infants with disorganized breathing pattern or with prolonged apnea, or excessive periodic breathing.[9]

The purposes of this epidemiologic study is to ascertain the current status of families and subsequent children within the past 6 years (1977-1982) who have experienced a SIDS infant in the state of Nebraska.

Methods and Materials

A questionnaire was sent to 291 members of the Nebraska Chapter of the National SIDS Foundation. Members of this organization include parents, other relatives of SIDS victims, public health professionals and institutions. As we did not know who were parents and who were not, or in what year the child of a SIDS parent had died, we chose to send the questionnaire to all members.

A total of 181 questionnaires were returned for a response rate of 62%. 126 of the respondents stated that they were parents of SIDS children; 16 were parents of SIDS cases who died in other states. In 32 cases, the SIDS child had died prior to 1977; in 6 others, the year of death was not given. The questionnaire data was unclear for 5 others. These groups were excluded from the study.

The analyses were applied to data from 67 parents of SIDS children who died in the state of Nebraska.

Results

Table I shows the number of respondents by year of death of SIDS infants compared to state statistics on the total number of SIDS deaths for the years 1977-1982. The table shows that information was obtained from parents of about ⅓ of all SIDS cases who died in the state between 1977 and 1982. Parents of over half of SIDS cases who died in Nebraska in 1981 and 1982 participated in the study, in contrast to 16% for the year 1977.

Table II shows the age of death of 67 SIDS infants as reported by their parents. Age at death ranged from 8 days to 19 months, but most commonly at 1-2 months.

TABLE I. Number of SIDS respondents reported and total number of SIDS deaths.

Year of Death	Total Respondents	Total # SIDS NE Bureau of Vital Statistics	% Respondents
1977	5	32	16
1978	5	33	15
1979	7	29	24
1980	14	44	32
1981	21	35	60
1982	15	34	44
TOTAL	67	207	30

TABLE II. Age at death of 67 SIDS cases as reported by parents.

Age at Death (Mos.)	Number of Cases	Percent
≤ 1	7	10
1-2	21	31
2-3	11	17
3-4	10	15
4-5	8	12
> 5	10	15
TOTAL CASES	67	

TABLE III. Monitoring procedures in subsequent siblings of SIDS.

Type of Procedure	Year of Birth					
	1978-79		1980-81		1982-83	
	N	%	N	%	N	%
None	3	75	8	57	5	20
Pneumogram Only	0	0	1	7	5	20
Monitor Only	0	0	3	21	3	12
Both	1	25	2	14	12	48
TOTAL	4		14		25	

Thirty-one of the 67 parents (46%) reported that they had no subsequent children. The remaining 36 parents reported a total of 43 subsequent children. A summary of the history of SIDS-related monitoring procedures for these children is given in Table III. Of the 43 subsequent children, 16 (37%) had no history of either pneumogram or monitor according to parents. The data demonstrates that between 1978 and 1983 there was a three-fold increase in subsequent children tested by these procedures. During this period of time, monitoring became available in Nebraska. In 1982-1983, 12 subsequent infants or 48% had both a pneumogram and monitoring.

The results of the procedures performed on

TABLE IV. Use of SIDS-related procedures by parents of subsequent children.

Procedure/Results	No. of Cases		Percent	
Pneumogram	21		49	
Abnormal		10		48
Normal		11		52
Monitor	21		49	
1-2 months		5		24
3-6 months		10		48
7-12 months		2		10
Currently Ongoing		4		19

TABLE V. Marital status of 67 parents of SIDS children.

Current Marital Status	No. of Cases	% of Married Parents
Together	51	82
Separated	6	10
Divorced	5	8
Total Parents	62	
Single Mothers	1	
No Answer	4	
TOTAL	67	

subsequent children are shown in Table IV. Of 21 cases who were reported to have had a pneumogram, the results were abnormal for 48%. It was also found that 21 cases (49%) were reported to have been monitored for periods ranging from overnight to 12 months. According to the parents, 6 of the children who had been monitored had not had a pneumogram prior to monitoring. Of 11 children, 6 (55%) with normal pneumograms had been monitored. These results seem to indicate that parents often choose to have their subsequent children monitored whether or not results of the pneumogram was abnormal.

A summary of the marital status of parents of SIDS children is given in Table V. One of the 67 parents was a single mother; 4 cases elected to not answer this question. Of the remaining 62 couples, 5 (8%) had been divorced and 6 (10%) had been separated.

A summary of responses to questions relating to SIDS Foundation activities is given in Table VI by year of death of the SIDS child. A total of 45 of the 67 parents (67%) indicated that they had been contacted by a Public Health Nurse. Of the 45, 36 (80%) said that the contact had been helpful. In addition, 44 of 67 parents (66%) had been contacted by another SIDS parent and 36 of these (82%) said that the SIDS parent contact had been helpful. Table VII indicates that in a high percent of cases contact made by the Public Health Nurse or SIDS parents was helpful.

TABLE VI. Contact by Public Health Nurse and parents of SIDS children by year of death of SIDS child.

	No. of Cases Contacted		Percent	
Visited by PH Nurse:	45		67	
1977-1978		6		60
1979-1980		12		57
1981-1982		27		75
Contact by SIDS parent:	44		66	
1977-1978		5		50
1979-1980		15		71
1981-1982		24		67

TABLE VII. Parents response to Public Health Nurse and SIDS Parent Group.

Year	Public Health Nurse % Helpful Contact	SIDS Parent % Helpful Contact
1977-1978	100	80
1979-1980	67	80
1981-1982	81	83
TOTAL	36/45=80%	36/44=82%

Discussion

The success of the SIDS Foundation is well illustrated by the significant increase in rate of return of questionnaires in the later years of this study. As the parents understand the phenomenon of SIDS better through media information, contact by Public Health personnel and other SIDS parents, there is an increase in participation not only in the SIDS Foundation but also in the eagerness to participate in studies on SIDS. The low participation rate in the earlier years was probably due to families moving away, a phenomenon that is well known in SIDS survivors.

The three-fold increase in subsequent children tested by pneumogram and/or monitoring probably is due to several factors: increased awareness, availability of apnea monitors, availability of monitoring programs in the state. However, in 1982-1983, 5 siblings were not monitored. Is it because the physician was not aware that there was a SIDS in the family or is he/she not convinced that there is increased incidence of abnormalities in subsequent siblings? Or was the physician not aware of the availability of the monitoring centers in the state? As reported by parents, 48% (10/21) of pneumograms done on subsequent children were abnormal. The abnormalities found in those cases were: periodic breathing, prolonged apnea, apnea and bradycardia. All these abnormal findings have been previously found in other studies.[10]

The divorce rate in our sample is 8% and another 10% have been recently separated. However, it is not known if the divorce/separation took place before or after death of the SIDS child or how long the parents had been married. In Nebraska, the annual divorce rate is 8-9% for each of the first three years of marriage (Reference; Bureau of Vital Statistics, Nebraska State Department of Health, Statistical Reports, 1977-1982). Assuming most of the SIDS parents have been married for at least 3 years, an appropriate standard for comparison can be estimated as 24% ($1-0.915^3$). It is difficult to interpret these results since the significance of separation vs. divorce is unclear, and since it is reasonable to suppose that less stable families may be underrepresented among respondents and/or among the membership of the SIDS Foundation.

Conclusion

Though a limited sample is presented:

1) There is an increase in the SIDS related contact from about 40% prior to 1977, to 70% between 1980 and 1982

2) In more than 80% of the time the contacts have been found to be helpful. The remaining complaints of either the contacts were done too late or the counselor just asked questions instead of talking to parents. Some were found to be unprepared to deal with the situations and also not to be sensitive to the fathers' feelings. Only one family complained that the meetings were more of a discouragement than help.

3) Although there is no definitive evidence for increased SIDS in siblings in this study, there is enough evidence of increased abnormalities in these children such as: periodic breathing and apnea. It is incumbent upon the medical profession to make sure that siblings are monitored until there is a predictive test for those at risk.

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Iron Overload as a Result of Transfusion Therapy in a Patient with Adenosine Deaminase Deficiency

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SERIAL transfusions with fresh, irradiated red blood cells (RBC) have been used to treat a subgroup of patients with severe combined immunodeficiency (SCID) in which an enzyme, adenosine deaminase (ADA),[1] is deficient. Previous reports have focused on the immunologic response to red blood cell transfusions or the pathogenesis of SCID due to ADA deficiency. We describe a 6½ year old female with SCID secondary to ADA deficiency who developed significant iron overload over several years. This report draws attention to the need for heightened awareness of this problem and to the potential harmful effects of iron overload to the immune system.

Case Report

In March, 1977, a 3 month old white female was admitted to the hospital because of pneumonia and dehydration. Her past medical history and birth history were unremarkable. Her hospital course was complicated by the development of acute renal failure, urinary tract infection, persistent oral candidiasis, and persistent, severe lymphopenia. Immunologic studies (Table I) indicated a diagnosis of SCID with ADA deficiency. No histocompatible bone marrow donor was available so monthly transfusions with irradiated packed red cells was initiated.

At 13 months of age she was admitted with respiratory distress and a diagnosis of **Pneumocystis carinii** pneumonia was made by lung biopsy, which was successfully treated. She subsequently received six cultured thymus epithelial cell transplants over a period of 18 months (performed by Dr. Richard Hong, University of Wisconsin), with no improvement in immune function. Subsequently, she has been maintained on monthly irradiated red blood cell transfusions and remarkably has remained free of serious infections for 6 years.

Immunologic findings have remained markedly abnormal. Serum IgG and IgM were markedly depressed. Anti-B isohemagglutinin titer (patient is blood type A) was 1:1 at age 38 months. Antibody titers to polio virus types I-II, diphtheria, and tetanus were negative and were unchanged after killed polio and DPT booster immunizations. Cellular immunity, evaluated by **in vitro** mitogen response to phytohemagglutinin (PHA), Concanavalin A, pokeweed mitogen and by mixed leukocyte culture (MLC), have remained markedly depressed. The absolute lymphocyte count has remained consistently below 500/m.[3] There has been no increase in the number or function

TABLE I

Initial Immunologic Studies

Age: 3 months
B Cells (surface membrane immunoglobulins) - 1% (Normal 8-25%)
T Cells - 1% (Normal 55-75%)
Serum Immunoglobulins (mg/dl) IgG 92; IgM 30; Iga 9.5 (Normal IgG 300-550; IgM 25-60; IgA 8-34)
White Blood Count - 12,000 with 4% Lymphocytes
Skin Test - Candida: Negative
Lymphocyte Transformation to Phytohemagglutinin: Negative
Radiology - Absent thymus on chest X-ray
RBC ADA level - 0.21 units/10^8 cells (Normal 2.0-6.0 units/10^8 cells)

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*Reprint requests to: Roger H. Kobayashi, M.D., Department of Pediatrics, University of Nebraska Medical Center, Omaha, Nebraska 68105 of T-lymphocytes following transfusions. T-lymphocyte percentages have varied from 2-23%, while B-lymphocyte quantitation by sIg+ (surface membrane immunoglobulin) method have demonstrated a marked fluctuation (5-75%). Neutrophil and monocyte chemotaxis was normal as was luminol-enhanced neutrophil chemiluminescence (a measure of bactericidal activity). Serial serum ferritin levels were followed since age 31 months. Plasma transfusions (from a single donor) to provide passive antibody protection has continued since 39 months of age.

METHODS

Transfusion Protocol and Iron

Beginning at four months of age, enzyme replacement therapy in the form of monthly exchange transfusions with thawed, deglycerolyzed, irradiated type-specific packed red cells has been given. Originally 10 ml/kg of whole blood was removed and replaced with 20 ml/kg of packed red cells as recommended by Polmar et al.[1] This resulted in significant iron overload by 31 months of age. The replacement volume was decreased to 12 ml/kg of packed RBC's. Serum ferritin determined monthly by GAMMADAB method (I^{125} ferritin radioimmunoassay), remained persistently high (Figure 1), and at age 38 months, further assessment of the patient's iron status was performed. The transfusion protocol was altered so that the red cell volume removed exceeded the replacement by 10%, resulting in a negative iron balance for each transfusion. The total packed cell volume transfused was 15 ml/kg. The transfusion procedure was performed in two steps to minimize adverse hemodynamic effects. Fresh frozen plasma (15 ml/kg) was infused to achieve hemodynamic balance and to provide passive antibody protection. To minimize the risk of hepatitis and other blood-borne infections, only one donor was used.

RESULTS

Prior to 31 months of age, the only index of iron status was a normal serum iron and total iron binding capacity obtained at 21 months of age. When serum ferritin (Figure 1) was initially measured at age 31 months, it was found to be markedly elevated at 1,720 ng/ml (normal values - 7 to 142 ng/ml). At age 32 months, the transfused volume was decreased from 20 ml/kg to 12 ml/kg, but no decrease in serum ferritin values was noted. At 39 months of age, the present transfusion regimen was implemented resulting in a decline in serum ferritin levels to the current value of 119 ng/ml (Fig. 1).

Histologic examination of a liver biopsy

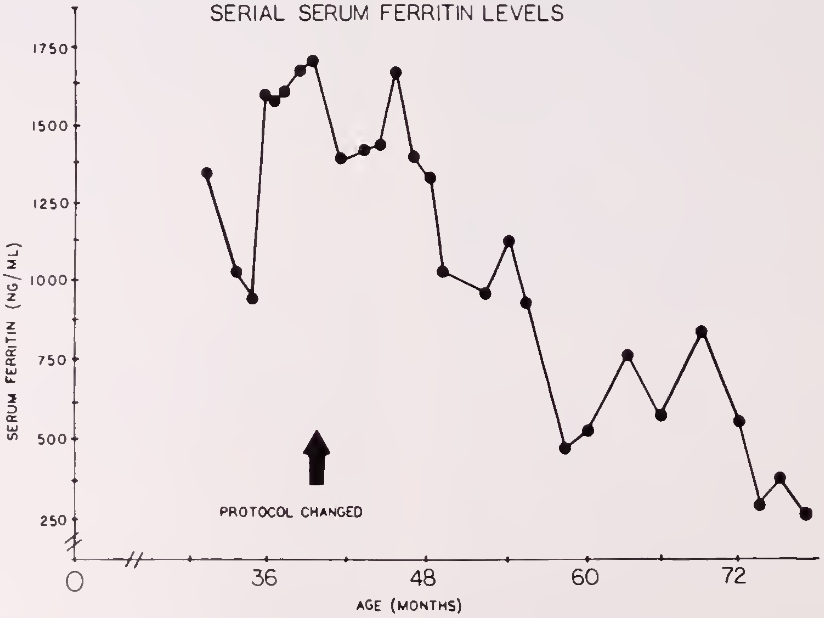

FIGURE 1. Declining serum ferritin levels following alteration in transfusion protocol for enzyme replacement in SCID.

done at 38 months of age revealed preservation of the hepatic architecture without evidence of fibrosis. Mallory-stained section showed a marked increase in iron pigment. Hepatic iron concentration was 198mcg-100 mg of wet liver (normal values - 10.8±5.8 mcg/100 mg of wet liver). However, no decrease in neutrophil and monocyte function, as measured by chemiluminescence and chemotaxis, has been noted.

DISCUSSION

Repeated monthly transfusions of ADA-rich red blood cells are regarded by some to be effective in the treatment of ADA-negative patients with severe combined immunodeficiency disease. Although this mode of therapy may partially restore immunocompetency, potential long-term complications from repeated transfusions can be serious. As suggested by Polmar, et al[1] potential problems in these patients include the development of hemosiderosis, the increased risk of hepatitis, and the development of antibodies against minor blood group determinants. Not generally appreciated but possibly a long-term risk is the impairment of the host immune system to combat infections which might occur when excessive levels of serum and tissue iron are present.

Transfusions of irradiated red blood cells have been administered to our patient for 76 months. Determinations of serum ferritin levels and hepatic iron quantification at 38 months revealed the presence of transfusional hemosiderosis. The long-term physiologic and pathologic consequences of iron overload include: 1) parenchymal deposition of iron, e.g. idiopathic hemochromatosis and 2) iron deposition primarily within the reticuloendothelial system due to repeated transfusions.[2] Parenchymal deposition of excessive iron results in multisystem organ dysfunction. Schafer, et al[3] suggest that short-term transfusion iron loading in adults can result in organ dysfunction resembling that of idiopathic hemochromatosis.

The potential adverse effects of iron overload on the immune system of a severely immunocompromised child are also worrisome. Iron excess may potentiate the pathogenicity of certain bacteria.[4,5] High levels of serum iron may cause inhibition of neutrophil function as suggested by Kaplan, et al,[6] who demonstrated a reduced ability of leukocytes to generate H_2O_2 in the presence of $FeSO_4$. Finally, saturation of the reticuloendothelial system may impair antigen clearance. In our patient and in other patients with severely compromised immune function, any impairment of the immune system, however subtle, could tip the delicate and tenuous balance in favor of infection.

In summary, our patient developed transfusional hemosiderosis secondary to enzyme replacement therapy for ADA-deficient SCID. Early recognition of this abnormality with serial serum ferritin levels allowed for alteration in the transfusion protocol to ensure a negative iron balance and still achieve enzyme replacement.

SUMMARY

A 6½ year old female with severe combined immunodeficiency secondary to adenosine deaminase deficiency received monthly transfusions with packed red blood cells since age 6 months. Iron overload was noted at 39 months of age requiring modification in the transfusion protocol. This report draws attention to the problem of iron overload in such patients and emphasizes the theoretically harmful effect on the immune system.

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President's Page

"MEDICINE IN TRANSITION"

ORGANIZED MEDICINE

Herbert E. Reese, M.D.

One would wonder how organized medicine would fare with the rather remarkable transformation in medicine that we have been discussing in these President's Pages the last few months. It is apparent organized medicine is not standing still. I was one of our attendees from Nebraska to the Interim House of Delegates of the American Medical Association that convened in Hawaii in early December, 1984. Nearly ten pounds of written material was evaluated, discussed, and acted upon by the House of Delegates at this remarkable meeting. Policy was determined and courses of action developed which will be summarized by our delegates and presented to our House of Delegates at the spring meeting of the Nebraska Medical Association. I would not be capable of commenting on the innumerable important issues, but there were four issues that I felt stood out in this meeting and deserve some comment. I would like to discuss these issues: pricing mechanisms, professional liability, the public image of the physician, and unified membership.

Pricing Mechanisms

Over the years, the patient has essentially been removed from the economic transaction of health care costs. This removal of consumer-payee has resulted in wide variations nationally in the cost of health services. A fair and effective price mechanism felt both by providers and consumers does not exist. As we all know, there are now many forces at work attempting to control these health care costs by a variety of schemes. The biggest payer for medical services, the government with its medicare funds rapidly approaching bankruptcy, is intent on cost control. We are all familiar with the fee freeze on medicare patients and the American Medical Association's lawsuit challenging the constitutionality of the Medicare amendments. Diagnostic related groups (DRG's) for physicians is to be reported July, 1985, to Congress by the U.S. Department of Health and Human Services (HHS). The American Medical Association is adamantly opposed to the DRG's for physician reimbursement as such a system has never been satisfactorily studied even on a pilot basis. The effect of such a system on patient care, and in particular complex illness, is entirely unknown. However, there is a high probability this system will be answered affirmatively by Congress, as there is a serious commitment to decrease cost. To head off this possiblity, the American Medical Association is actively working with HHS in the establishment of a national relative value scale. Previous relative value scales were based on actual fees. The present consideration is a "resource based" relative value scale taking into consideration cognitive and procedural services. Meetings with the different specialty groups have been initiated. A contract is being sought with the government for development of a relative value scale along the lines of equitable payments. Other considerations are negotiated fee schedules with the government. Organized medicine is at work on this extremely complex issue. We all understand the adverse effect on our patient's welfare if cost savings is the primary focus in the determination of pricing mechanisms. One has to appreciate the tremendous amount of effort being expanded by our American Medical Association, for I am afraid that, alone, we and our patients would lack any clout or representation.

Professional Liability

We have moved from professional liability insurance unavailability in the 1970's to affordability in the 1980's. The frequency of claims and damages awarded has climbed to record heights in most states. This trend has reached a crisis level over a large part of the nation, and one can only conjecture what lies in the future with the emphasis on less testing and less services. In June,1984, the American Medical Association created a special Task Force on medical liability chaired by Executive Vice-President James Sammons. This Task Force has compiled a three-part report on medical liability and is working in areas of a national education program, federal legislation regarding medical liability, model state tort changes, risk management and loss prevention, and legislative coalitions at local levels. A national toll free number (800-552-4642) has been established for professional liability questions. We in Nebraska have been somewhat insulated from this crisis with the overall amount of premiums paid by Nebraska physicians ranking among the lowest two or three states in the United States. Over the last few years, we have been paying only 1% surcharge of the primary insurance premium for excess liability coverage through the excess liability fund. In 1984, the legislature removed the five million dollar lid from the excess liability fund, and now the fund has to be at a level which will satisfy sound acturial principles. So we in Nebraska will have an increase in premium for excess liability to increase the reserves in this fund. A letter of explanation to all Nebraska Medical Association members was sent in January of this year. With professional liability premiums, Nebraska physicians have been fortunate due to past and ongoing activity of our own Nebraska Medical Association.

The Public Image of the Physician

During the past decade, the American Medical Association has closely monitored the opinions of physicians and the public on key health care issues. This monitoring has been accomplished through an independent consulting firm. The most noteworthy aspect of these public opinion polls is that the public apparently feels more favorably inclined toward their own doctors than they do toward doctors as a group. The individual physician must be doing a good job, but collectively in the community, physicians are perceived poorly. This image gap of the public's viewpoint of the individual's own physician to the collective group of physicians can vary as much as 50%. People's attitudes toward doctors in general must necessarily be based on secondary information and hearsay. Therefore, it is apparent that public relations in the medical profession as a whole need attention while the positive image of the individual physician is intact without it. The American Medical Associaton has multiple programs, many of which will be coordinated into the states to reverse this image gap of the public. Many states are developing active programs to improve their public image. Kentucky, for instance, has an indigent medicine program. Physicians sign up to care for the indigent. Indigent is defined as patients over medicaid and below poverty level. They have developed a toll free number for access to this program. This has been an excellent program with a much improved image. Physicians have been caring for patients without funds for years. It is time we take credit. Efforts are needed nationally and locally in this area.

Unified Membership

Membership in the American Medical Association is at its lowest. Less than 50% of the physicians in the United States belong to the American Medical Association. There are too many of us content to let our colleagues pay the bill. This apathy at a time when unification is so necessary. Only two states have unified membership; they are Oklahoma and Illinois. Unified membership means a physician has to be a member of both his state association and the American Medical Association and cannot be a member of one alone. With our rapid transition in medicine today, there is a good argument for a return to unified membership. Each of our state Councilors contacted five or more non-members regarding membership and found a remarkable acceptance rate. Our non-member colleague simply needs that personal contact.

Of all the many benefits of organized medicine, representation is by far the most important. There is no other effective way: politically, ethically, economically, scientifically, or legislatively. Representation cannot be accomplished individually or by small groups. Never has representation in medicine been more important than through this transition. Our collective voices must be heard. There are many forces out there that will engulf us, and then the patient loses his/her true advocate. Let us be reminded that we need REPRESENTATION in this remarkable transition and that it only comes through our organizations: local, state, and national.

Herbert E. Reese, M.D.

Letter to the Editor

Jerald Schenken for AMA Trustee

"He's Our Guy"

Nebraska has been afforded a unique opportunity to have one of our own physicians elected to the Board of Trustees of the American Medical Association. Jerald R. Schenken, M.D. of Omaha, Alternate Delegate of the College of American Pathologists to the AMA, is being sponsored by the Nebraska Medical Association and has the endorsement of the North Central Medical Conference (NE, IA, MN, ND, SD, & WI) in his bid for this prestigious office. We need the backing and support of our entire membership if we are to be successful in Jerry's campaign.

Those who know Jerry personally are aware of his many talents and his long service to Nebraska and American medicine. His reputation and performance resulted in his selection as a member of the AMA's Council on Legislation, the group of physicians who study and develop strategies for constituent societies and orchestrate the presentation of testimony on National Legislative issues which affect the practice of medicine and the health of our nation. He was recently elected chairman of this 14 member council by his fellow members, who recognize his intelligence, industry, intensity, integrity, indefatigability, and eloquence and he has been encouraged to seek this post by a number of current officers, trustees, and influential members of the AMA House of Delegates.

He is a topnotch candidate and the first Nebraskan to seek the office of AMA Trustee in my memory if not the first ever. The members of the Nebraska AMA delegation are committed to give this race 'our best shot'. John D. Coe, AMA delegate from Omaha, is Dr. Schenken's campaign manager and is in the process of mapping out the campaign strategy. If any NMA members are good friends, associates, or classmates of AMA Delegates or Alternate Delegates from other states or specialty societies, I'm sure Dr. Coe would like to have that information.

You can imagine the enormity of our task when you consider that Nebraska has only 3 delegates and the North Central Medical Conference has only 22 delegates out of a total of some 364 or more voting delegates in the AMA House. The odds notwithstanding, your AMA delegation intends to go all out for Dr. Schenken's election but need the ideas, suggestions, and cooperation of all members of the Nebraska Medical Association. Keep those cards, letters, and phone calls coming in so that we can be successful in electing Jerald R. Schenken, M.D. to the AMA Board of Trustees in 1985.

C. J. Cornelius, Jr., M.D.
Chm. Nebr. AMA Delegation

In Memoriam

By medicine life may be prolong'd
yet death
Will seize the doctor too.
—Shakespeare

William F. Roth, Jr., M.D. — (Born February 25, 1904 - died November 23, 1984) — Medical Specialty — Psychiatry. Doctor Roth was a graduate of Yale University School of Medicine in 1929. He was a member of the American Medical Association and the Nebraska Medical Association. Survivors include his widow, Dorothy; sons, John C. Roth of Nashville, TN; and C. Vance Hubbard of Portland, OR; a daughter, Dorothy Zimmer of Amarillo, TX; six grandchildren; and three great-grandchildren.

A. P. Stappenbeck, M.D. — (Born September 3, 1912 - died December 21, 1984) — Medical Specialty — General Practice. Doctor Stappenbeck was a graduate of the University of Nebraska College of Medicine in 1938. He was a member of the Nebraska Medical Association.

Welcome New Members

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McCook, NE 69001

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Omaha, NE 68127

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Omaha, NE 68122

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James W. Billups, M.D. (Reinstated)
Rt. 1, Box 220
Nebraska City, NE 68410

David H. Baras, M.D.
P.O. Box
Omaha, NE 68134

The Auxiliary

Caring for Kids in the '80's

Saturday, March 23, 1985

Lancaster County Medical Auxiliary
and
Southeast community college

An interdisciplinary seminar for parents, social workers, school personnel, child care providers, and health professionals who live and work with children.

Program Presenters:

**Edward R. Christophersen, Ph.D., is Professor of Pediatrics and Chief of Behavioral Science Section at the University of Kansas Medical Center, where he works in the outpatient Pediatric Clinic, teaches in the medical and nursing school, and lectures in prenatal classes.

Charles Erickson, M.D., is a pediatrician in the Lincoln Pediatric Group and a consultant to Lincoln-Lancaster County Child Guidance Center and Lincoln Public Schools Preschool Handicapped Program. He is also Clinical Assistant Professor in the Department of Pediatrics, University of Nebraska College of Medicine.

Kenneth D. Keith, Ph.D., is Associate Professor of Psychology at Nebraska Wesleyan University. He is a consultant to Nebraska Regional Mental Retardation Programs and public schools, with a special interest in children and families and persons with developmental disabilities.

Robert G. Osborne, M.D., is a psychiatrist in private practice, an attending staff member at Lincoln General Hospital, and a member of the Board of Trustees. He is also chairman of the Ad Hoc Committee on Psychiatry of the Nebraska Medical Association.

Sandra J. Shadley, M.A., is counselor/consultant at Child Guidance Center and coordinator of the "Children of Divorce" project.

**Dr. Christophersen is brought to Lincoln by Ross Laboratory and the Lancaster County Medical Auxiliary.

Practical approaches useful in working with children will be presented by professionals in the fields of child psychology, psychiatry, pediatrics, behavioral medicine, and counseling. Topics include communicating with children, causes of behavior, common problems, and questions in child development plus five special interest sessions.

Southeast Community College 8800 "O" Street Room B-7

(Park in South lot.)

Program Agenda

8:30 a.m.-9:00	Coffee and rolls
9:00-10:45	**Caring for Kids in the 80's** Dr. Christophersen
10:45	**Break** for beverages
11:00-12:00	**Special Interest Workshops**
12:00-1:00	**Lunch** (included in fee)
12:45-1:00	Books available for purchase and autographing
1:00-2:00	**More About Kids** Dr. Christophersen

2:00	**Stretch Break**
2:15-3:15	**Special Interest Workshops**
3:15-3:45	**Panel Discussion**, questions and answers
3:45	**Evaluation and Adjourn** Books available for purchase and autographing

Special Interest Workshops

Participants may attend one session in the morning and one in the afternoon. Indicate choices on registration form.

A Basic Behavior Principles — Why Children Do What They Do
Dr. Ken Keith

B Problems of Single and Divorced Parents
Sandra Shadley

C Children With Special Needs — Hyperactivity, Chronic Illness and Those Undergoing Painful Procedures
Dr. Charles Erickson

D Little People — A Common Sense Approach to Infant Care
Dr. Christophersen

E Suicide in Children and Adolescents — What to Look For — What to Do
Dr. Robert Osborne

Participants will learn to:

- Change the behavior of children with whom you work and live.
- Nurture healthy self concept in children.
- Evaluate normal and abnormal behavior and developmental patterns in children and youth.
- Give physical, psychological, and emotional support to children with special needs.

Dr. Christophersen has authored two books which will be available for purchase and autographing at designated times. The books are *Little People* and *The Baby Owner's Manual.*

Contact hours have been applied for from the Nebraska Nurse's Association. If approval is important to your registration, you may telephone SCC between March 1 and 15 to inquire (471-3333, ext. 251).

The workshop will be held at Southeast Community College, 8800 "O" Street, Lincoln, Nebraska in Room B 7, which is at the south end of the building.

Tuition is $10 which includes lunch.

Registration deadline is March 15.

Cut off and return to SCC Adult Education Department, P.O. Box 5788, Lincoln, NE 68505-0788.

Include check for $10.00 to SCC.
Registration Deadline: March 15

CARING FOR KIDS IN THE 80'S

Name ____________________
Address ____________________
Town ____________ Zip ________
Day Phone ____________ Evening Phone ____________
Social Security Number ____________________

Special Interest Workshops
Please indicate 1st and 2nd choice for both times.

Workshop 11:00
Workshop A ________
Workshop B ________
Workshop C ________
Workshop D ________
Workshop E ________ (offered only at 11:00)

Workshop 2:00
Workshop A ________
Workshop B ________
Workshop C ________
Workshop D ________

Coming Meetings

1985 ANNUAL SESSION — April 26-29 — Lincoln Cornhusker

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSN. — Executive Committee Dinner, Sunday, March 24, 1985, 4:00 p.m., Social, followed with meeting and dinner, Omaha Marriott Hotel. Executive Committee and spouses urged to attend.

THE MATERNAL AND CHILD NUTRITION CONFERENCE — March 28-29, 1985. The focus of the meeting will be on the medical, nutritional, and social implications of teenage pregnancy. The location of the meeting is the East Campus Union, University of Nebraska, Lincoln, NE. Continuing education credits have been applied for from the American Dietetic Association, Nebraska Nurses Association and the Dietary Managers Association. Cost for the two days will be $25.00. For more information contact Eileen Douglass, Nebraska Department of Health - Nutrition Division, 301 Centennial Mall, South, P.O. Box 95007, Lincoln, NE 68509. Phone (402) 471-2781.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSN. — Alumni Reception, Saturday, March 30, 1985, 5:30-7:00 p.m. In conjunction with Nebraska Academy of Family Physicians Meeting, Omaha Marriott Hotel, cash bar. All alumni and guests cordially invited.

UNIVERSITY OF NEBRASKA COLLEGE OF MECIDINE — ALPHA OMEGA ALPHA, AOA Day, Wednesday, April 24, 1985, UN Medical Center, Omaha, Nebr. Speaker: Robert D. Sparks, M.D., President, Chief Programming Officer, and Trustee, W. K. Kellogg Foundation, Battle Creek, Michigan. Convocation: 12 noon, Wittson Hall Amphitheater, UNMC Campus. Everyone welcome to attend. AOA Banquet: 6:00 p.m., Highland Country Club, Omaha.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSN. — Annual Business Meeting, Saturday, April 27, 1985, in conjunction with Nebraska Medical Association Meeting; 4:30 p.m. in Room F, Convention Center, Cornhusker Hotel, Lincoln. Alumni are urged to attend; spouses and guests are welcome.

CREIGHTON UNIVERSITY

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 3-8, 1985. Sponsors: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 25 hrs. AMA Category I. Fee: $400 Physicians, $200 Residents. Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology, Endocrinology, Pediatric and Adult Cardiology.

UNIVERSITY OF KANSAS

For additional information on the following University of Kansas meetings contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, KS 66103, Telephone (913) 588-4480.

REVIEW AND UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — March 2-9, 1985. Sponsor: Creighton University School of Medicine, University of Kansas College of Health Sciences, University of Nebraska College of Medicine. Location: Sheraton Hotel, Cancun, Mexico. Credit: 24 hrs. AMA Category I, 24 hrs. AAFP. Fee: $400 Physicians, $200 Residents. Topics: Infectious Diseases, Pediatric Orthopedics, Dermatology Endocrinology, Pediatric and Adult Cardiology. Contact Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Ave., Omaha, NE 68105, (402) 559-4152.

ADVANCED CARDIAC LIFE SUPPORT — March 20-21, 1985, May 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Building, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $150 physicians, $75 nurses, EMTs. Credit: 13.5 hrs. AMA Cat. I, 13.5 hrs. AAFP, American Heart Association Certification.

REHABILITATION MEDICINE: OFFICE MANAGEMENT OF MUSCULOSKELETAL PAIN SYNDROME — March 25-26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: Hours TBA for Physicians, Nurses, Physical Therapists.

COMMUNICATING WITH CHILDREN (HEARING AND SPEECH) — April 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians and Speech/Language/Hearing Clinicians.

35TH ANNUAL SYMPOSIUM ON ANESTHESIOLOGY — April 19-21, 1985. Sponsor: University of Kansas Medical Center. Location: Westin Crown Center Hotel, One Pershing Road, Kansas City, Missouri. Credit: 15.5 hrs. AMA Cat. I, 14 hrs. AAFP, 14 hrs. AANA. Fee: $225 Physicians, $150 Nurse Anesthetists.

11TH ANNUAL FAMILY PRACTICE SYMPOSIUM — April 24-25, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for physicians.

29TH ANNUAL SYMPOSIUM ON INFECTIOUS DISEASE — April 26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

ANNUAL PATHOLOGY SYMPOSIUM — April 27, 1985. Sponsor: University of Kansas Medical Center. Location: Rieke Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

SAM E. ROBERTS NUTRITION PROGRAM: MINERALS IN HUMAN NUTRITION — CLINICAL APPLICATION — April 30, 1985. Sponsor: Academy of Health Professions and University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $100 Physicians, $40 Nurses, Dietitians, Allied Health Professionals, no charge to students and residents. Credit: 7 contact hours each for physicians, nurses, dietitians, physical therapists, and respiratory therapists. Contact: Ida Tilden, Academy of Health Professions, 2920 McGee Trafficway, Kansas City, MO 64108, (816) 531-4559.

WHAT'S NEW IN DIABETES? — May 1, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: AMA 7.5 hrs. Cat. I, AAFP 7.5 hrs., CNE 8 hrs., Dietitian 8 hrs., SW 8 hrs.

DIABETES FOR PHYSICIANS — May 2, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Missouri. Credit: AMA 4 hrs., AAFP 4 hrs. Fees: $10 (includes lunch).

TECHNOLOGICAL ADVANCES IN RESPIRATORY CARE — May 9-10, 1985. Sponsor: University of Kansas Medical Center. Location: Hilton Plaza Inn, 45th and Main, Kansas City, Missouri. Credit: 11 hrs. AMA, AAFP, CNE, RT, CRNA.

KANSAS MEDICINE: TEN YEARS LATER — May 17, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 6 hrs AMA, AAFP.

ADVANCED CARDIAC LIFE SUPPORT — May 21-22, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Bldg., University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA, 13.5 hrs. AAFP. Fees: $150 physicians, $75 nurses, EMTs.

THE CHILD WITH CHRONIC DISEASE — May 23-24, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA, AAFP, CNE.

ADVANCED TRAUMA LIFE SUPPORT — May 30-31, 1985. Sponsor: University of Kansas Medical Center. Location: Orr-Major Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 16 hrs. AMA, 15 hrs. AAFP, 15 hrs. AOA. Fees: $375. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-6124.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — June 13-14, 1985. University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA. Fees: $625.

SCHEDULED MEETINGS

37TH ANNUAL MIDWEST CANCER CONFERENCE — March 8-9, 1985, Hilton Inn East, Kellogg and Rock Road, Wichita, KS. Friday Session — Title: Breast Cancer: Can We Reach a Consensus? Saturday Session — Title: Effective Screening for Colon Cancer: Flexible Sigmoidoscopy. Title: Skin Cancer: Selected Topics.

WashingtoNotes

(Continued from page 20a)

The proposed regulations are different from the "section 504" regulations issued last year and twice rejected by the courts. Whereas the earlier regulations were based on laws prohibiting discrimination of the handicapped, the new regulations are based on laws prohibiting child abuse. There are important philosophical differences: the earlier "504" regulations insisted that handicapped children be provided the same care as non-handicapped children, the new regulations say that handicapped children be provided the best care for their certain circumstances, and admit that there are circumstances when no care at all is the best course.

The earlier "504" regulations demanded federal intervention, with hotlines and investigative squads. The proposed regulations leave all intervention up to state authorities (some state child abuse programs already have hotlines and conduct investigations). The exact implementation of the law will depend on procedures set up by each state.

In an unrelated action, HHS asked for comments on guidelines that establishment of Infant Care Review Committees (ICRs) in hospitals that care for infants, especially those with tertiary level neonatal care units. Although the committees are not required, they could educate hospital personnel, recommend institutional policies, and offer counsel and review in Baby Doe cases, HHS stated.

* * *

America's Proposed National Disaster Medical System

India's recent gas leak sent more than 10,000 people to hospital emergency rooms, but hundreds of victims were treated on the lawns outside the city's hospitals because all the beds were full.

In the Mexico City gas explosion, burn patients crowded into hospital hallways; churches and a subway station became first aid centers. Blood, plasma, and medical supplies ran dangerously short in the seven hospitals treating the city's 3,000 victims.

How could the United States respond to similar disasters?

Trained medical assistance teams could rush to the scene to perform field rescue and first aid. The most critically injured would receive surgery at the disaster scene; the less seriously injured would receive first aid until ready for evacuation. As many as 100,000 patients could be distributed to hospitals awaiting them with supplies and personnel.

The planned National Disaster Medical System is being developed in response to President Reagan's 1981 mandate to improve emergency preparedness. Modeled after a Department of Defense plan to handle excess casualties in military conflicts, the NDMS is designed to respond to a wide range of emergency situations. Two pilot disaster units are already operating; others will form within the next three years.

NDMS will provide nationwide medical help when local, state, and regional facilities are overwhelmed by a serious disaster, Thomas P. Reuthershan of the Department of Health and Human Services said recently. It is not designed to replace local disaster relief teams but will supplement local efforts with a broad-based network of national support.

The system would be triggered by three situations: a Presidential declaration of a major disaster, a state request for help, or a major war or national security emergency.

The U.S. now has the lowest number of available hospital beds in history. NDMS could support only a conventional, non-nuclear war in which the U.S. is not under direct attack, authorities note; a nuclear war would overwhelm the capabilities of the NDMS system.

No single community can be fully prepared for war or a catastrophic event, said Reuthershan. Although all cities and states are well-stocked with medical supplies, it is virtually impossible to anticipate a sudden surge of injuries.

The system is a showcase of private-sector volunteerism. It would require no new hospital construction. Nor would it demand the purchase of extra equipment, or training of special staff.

Although modeled on Washington, DC, the actual implementation of the system is decentralized in 71 communities across the country. A national center — composed of representatives of the Department of Health and Human Services, Department of Defense, Federal Emergency Management Agency, the Red Cross, and other federal and private health agencies — would manage the federal response to a disaster.

Medical teams would be trained as volunteers, although compensated for their work during an actual emergency. Hospitals of 100 or more beds would also enroll, volunteering to participate in training and exercise programs but receiving compensation for each patient. Medical supplies would be provided by preexisting Packaged Disaster Hospitals; patients would be evacuated on Air Force helicopters, or on commercial jets, trains, and buses.,

* * *

Congress' OTA Looks at ICUs

Because intensive care unit (ICU) patients are "revenue losers" under the diagnosis-related-group (DRG) system, hospitals may feel pressure to change the way they offer ICU care, a new Congressional office of Technology Assessment study concludes.

"The new incentives of the DRG payment system will be imposed in many hospitals in which the costs of ICU care had previously been a relatively minor concern," according to a report of the study.

Hospitals may decide to reject ICU cases, transfer them to other facilities or accept them at a loss. They may ration ICU care to only certain favorable-outcome cases, or impose cost-controls on ICU physicians, it states.

ICU decision-making could become even more difficult due to the potential financial conflict between patients, physicians, and hospitals, the report warns.

ICU hospitalization days are 3-3.5 times more costly than non-ICU days. In addition, ICU patients have longer hospital stays than non-ICU patients. It has been estimated that 15-20% of all patients are cared for in an intensive or coronary care unit at some point during their hospital stay.

A very small portion of the ICU patient population consumes a substantial portion of total ICU resources. ICU care appears to be well-invested in cases of acute, reversible disease such as a drug overdose or major trauma; ICU care may be less cost-effective in severe, debilitating chronic illnesses such as cancer or cirrhosis, the report states.

Until recently, ICU care has not been subject to the same restraints as intermediate or general care. For example, 1980 Medicare rules tightened the payment limits on routine bed costs but not on ICU bed costs. Furthermore, utilization review boards generally do not consider the appropriate level of care within a hospital.

ICU physicians feel little incentive to keep the unit empty or restrict technical procedures. The current system of physician payment — based on a usual, customary, and reasonable charge system — has rewarded physicians who provide abundant ICU services. Additionally, there are non-financial reasons to provide ICU care: it is difficult to predict an ICU patient's chances of survival; ICU patients are often mentally incompetent; and the threat of lawsuit encourages continuationm, rather than withdrawal, of care.

OTA predicts that the new payment environment may change hospitals' attitudes about the appropriateness and extent of ICU care. ICU patients are expensive: they often have multiple diagnoses and suffer severe health problems that do not fit nearly into DRG disease "entities". In one study, ICU patients had an average of four major diagnoses; high-cost nonsurvivors had six diagnoses.

The DRG classification scheme may be poorly suited to describing ICU patients, it says. For example, severity of an illness is not taken into consideration. Gastrointestinal bleeding in patients with cirrhosis is associated with long ICU lengths of stay, yet the DRG for cirrhosis has a mean special care length of only 0.6 days.

Nor does the DRG system take into account those ICU patients with a primary surgical diagnosis who suffer major medical complications. For example, hospitals which treat patients with renal failure are reimbursed based on the operating room procedure, not the ICU care needed to sustain non-functioning kidneys.

The DRG payment system does allow additional payments for 'outlier' cases, which have long lengths of stay or are unusually expensive, it notes. However, the outlier policy pays hospitals less than the marginal costs of caring for the sickest ICU patients.

Because there is no financial penalty for transferring patients to another hospital, the sickest ICU patients may be moved to tertiary care facilities, it predicts. The hospital which keeps a patient only four days get paid 40% of the DRG total payment; on the other hand, a hospital which must keep the patient until he recovers — or dies — is less likely to recoup its full investment.

If the trend continues, tertiary care hospitals may inherit most ICU cases. They may reject them, accept them at a financial loss, or try to minimize expenses by converting separate ICUs into larger, more centralized, and more general ICUs. They may substitute lower-paid health personnel for nurses and physicians when cases require only routine monitoring. Or there may be new efforts to find cost-saving technologies that will replace expensive ICU labor, according to OTA.

Tertiary care hospitals could become, in effect, large ICUs. They may place cost controls on their ICU physicians, paying them salaries as the major form of renumeration. New incentives, like physician bonuses for reduced costs or decreased lengths of stay, could be proposed.

The report suggests several steps to ease ICU decision-making:

* increase research to pinpoint the predictors of survival in ICU patients with various illnesses.
* evaluate and perhaps modify the current DRG method of payment for ICU cases,
* recognize the current conflict between law and medicine: high malpractice standards vs. limited medical resources,
* better educate physicians about medical ethics and legal obligations,
* create formalized decision-making committees in hospitals to lessen the burden on physicians faced with difficult choices about ICU treatment.

* * *

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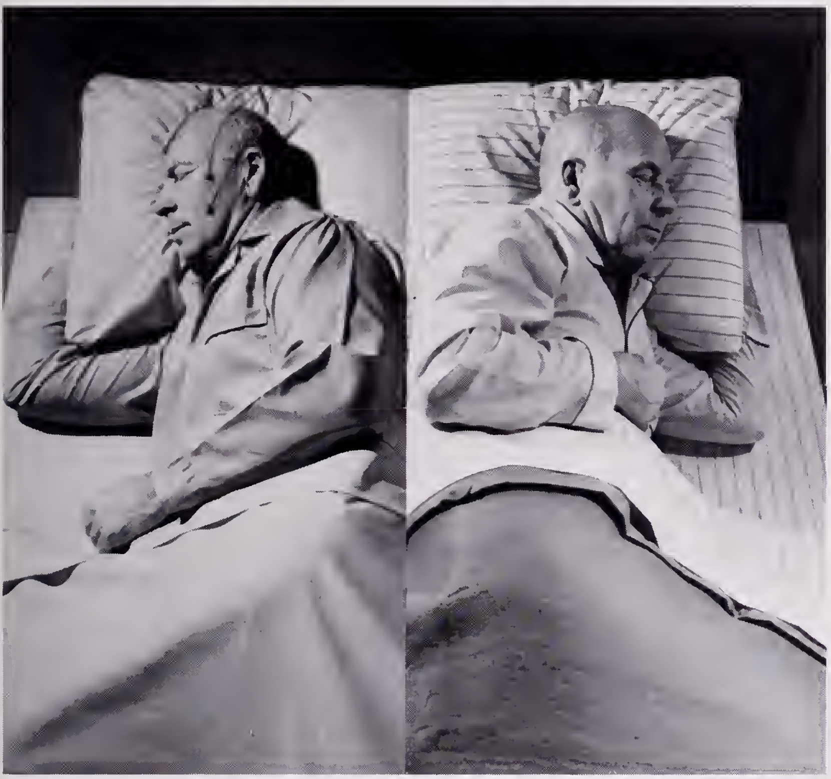

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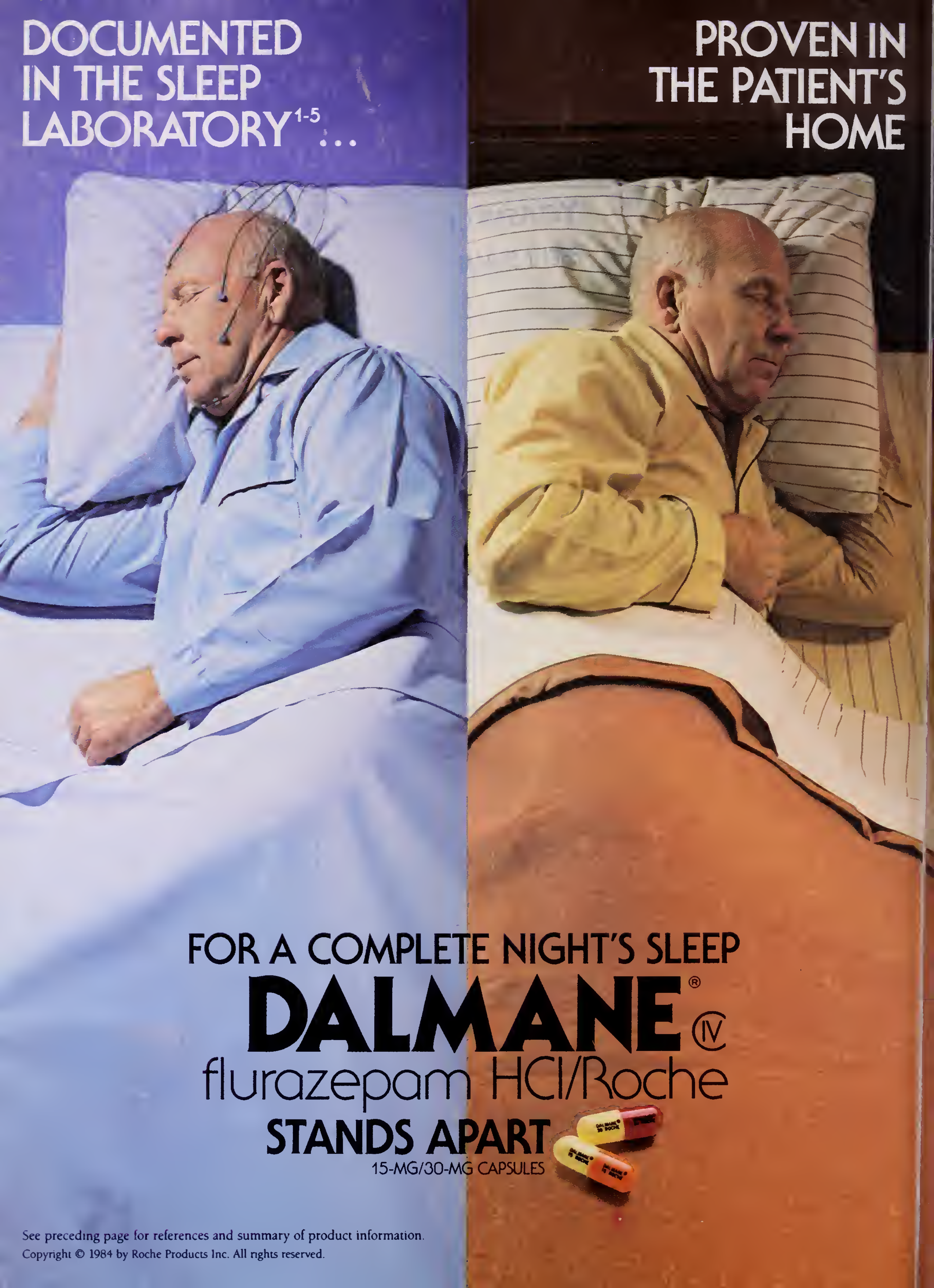

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NEBRASKA MEDICAL ASSOCIATION
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The objective of this course is to review current controversies regarding the treatment of asthma. This will include the use of theophylline and metaproteranol.

NEBRASKA SOCIETY OF ANESTHESIOLOGISTS

This program will present a clinical update on two diverse clinical subjects, anesthesia for trauma and obstetrics. A presentation on professional liability will provide a non-clinical balance and should be of interest to all.

AMERICAN CANCER SOCIETY

This course will present the most common cancer in the State of Nebraska, colo-rectal cancer. The objective of this course it to emphasize early detection and treatment of colo-rectal cancer, an effort which can return three out of four patients to normal active lives.

MISSOURI VALLEY DERMATOLOGIC SOCIETY

This course is divided into two sections, the first presenting common dermatologic conditions seen in general clinical practice. The second section will deal with specific skin problems seen in a pediatric patient population focusing on eczema, congenital lesions, and acne, including the use of Accutane.

NEBRASKA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

This course is designed to give the clinician a better understanding of poisoning -both the obvious and the not so obvious with emphasis on management and caveats of care.

NEBRASKA HEART ASSOCIATION LINCOLN DIVISION, and the NEBRASKA CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

This course is designed to review both cardiac and pacemaker arrythmias with emphasis on diagnosis and treatment. In addition, cost effective evaluation of dysrhythmias as well as pacemaker indications will be presented. There will be discussion on pharmacologic agents as well as drug inter-actions. This course is aimed at both primary care and subspecialty physicians who deal with cardiac patients.

NEBRASKA ACADEMY OF OPHTHALMOLOGY

The general topic of this course will be Strabismus. The speaker will be William E. Scott, M.D., Professor of Ophthalmology, Department of Ophthalmology, University of Iowa Hospitals and Clinics, Iowa City, IA.

NEBRASKA ACADEMY OF OTOLARYNGOLOGY

The title of the program will be "Management of Cancer in the Neck." This course will cover the management of metastatic squamous carcinoma of the neck, including N_0 neck. Different modalities of cervical lymph node dissection will be discussed, including the indications and technique of the functional neck dissection.

NEBRASKA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

The objective of this course is to update the primary care physician in areas of adolescent medicine.

NEBRASKA PERINATAL ORGANIZATION

The Nebraska Perinatal Organization will present speakers covering such topics as outcomes of the very low birth weight infants, neonatal seizures, the frustrated perinatal nurse, use of antibiotics in premature labor, home phototherapy, and stillborns in Nebraska.

NEBRASKA RADIOLOGICAL SOCIETY

This course is designed to present topics of current interest to practicing radiologists.

NEBRASKA CHAPTER, AMERICAN COLLEGE OF SURGEONS

This course is designed for Candidates and Fellows of the American College of Surgeons to act as a forum for presentation of papers of current interest.

NEBRASKA THORACIC SOCIETY

This course is designed to discuss the current methods of diagnosis for esophageal reflux, prevention of aspiration and treatment of esophageal reflux and aspiration pneumonia.

NEBRASKA MEDICAL ASSOCIATION AUXILIARY

The Auxiliary-sponsored portions of the Annual Session will include its Annual Board Meeting on Friday morning, a progressive dinner Friday evening, the brunch and presentation of awards Saturday morning, a meeting of the Gavel Club Friday afternoon, and the meeting of the new Board on Sunday.

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Share An Evening With The President

at the annual Inaugural Banquet, 1985 Annual Session
Nebraska Medical Association
Cornhusker Hotel, Lincoln, Nebraska
April 28, 1985

"If We Don't Care, Who Does?"

Joseph F. Boyle, M.D.
President
American Medical Association

Dr Boyle

Physicians and their spouses are urged to plan attendance at the Inaugural Banquet as one of the highlights of the 117th Annual Session. Dr. Frank D. Donahue will be installed by Dr. Herbert E. Reese to launch the new year for the Nebraska Medical Association.

Dr. Boyle is a veteran leader in the AMA who has also been highly honored for leadership in his specialties--internal medicine and diseases of the chest. His community and state-wide leadership from his home in Los Angeles, and ten years experience on the AMA Board of Trustees, provides him with an excellent base from which to speak with authority on the critical issues facing medicine today.

The Eighth Annual Black Hills Seminar

on Advances in Clinical Pediatrics

June 19, 20 and 21, 1985
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Custer, South Dakota,

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For complete conference information contact:

Lawrence R. Wellman, M.D.
Program Coordinator
USD School of Medicine
1100 S. Euclid, P.O. Box 5039
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WashingtoNotes

President's Budget Again Would Cut Medicare/Medicaid

As has each budget since his first election, President Reagan's fiscal 1986 budget proposal includes substantial cuts in Medicare and Medicaid.

For Medicare, some $4.2 billion in first-year savings would be achieved by increasing beneficiary premiums, reducing funding for graduate medical education, and freezing payments to hospitals, physicians, clinical labs, nursing homes, and other providers. The federal Medicaid contribution would be capped to save $1 billion in 1986.

All told, the proposed budget reduces an estimated $45.2 billion Medicare payment hospitals in fiscal 1986 by about $2.7 billion; a projected $17.8 billion expenditure for physician services would be cut by about $500 million. About 63% of Medicare savings would come from the hospital cuts and 12% would flow from the extension of the current physician fee freeze.

(Continued on page 12A)

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WashingtoNotes

(Continued from page 6a)

The proposals, which are part of a $330 billion budget for the Department of Health and Human Services, would hold Medicare cost increases to 2% and Medicaid increases to 3% at a time when enrollees in the two programs are expected to climb by 2% and 1.7% respectively.

The proposals include:

* A 12 month extension of the physician fee freeze enacted last summer and scheduled to end October 1. This would apply to both participating and nonparticipating physicians. Estimated fiscal 1986 savings are $500 million.

* A freeze on diagnosis related groups prices for hospitals. Expected savings are $1.8 billion in 1986.

* A cap on payments for direct costs of medical education projected in 1986 to shave about $150 million from payments that currently total about $1 billion.

* The elimination of the current doubling (from 5.795% to 11.59%) of the Medicare adjustment for indirect medical education costs. Estimated savings from the plan are $695 million in fiscal 1986.

* Staged-in increases in Part B premium increases so that by 1990, premiums would cover 35% of program costs. Medicare income would be increased by $334 million in fiscal 1986.

* Cap the fiscal 1986 federal payment to states for Medicaid benefits at $22.2 billion or about $1.3 billion less than projected under current law. A $300 million hardship fund would be created for states that had large cost increases despite efforts to curb costs.

Congressional criticism of the physician fee freeze centers primarily on the belief that it breaks a promise to participating physicians who were to have had potentially higher fee increases at the end of the freeze. HHS Secretary Heckler said she doesn't believe the freeze breaks a promise to the participating physicians and Health and Care Financing Administration head Carolyn Davis, Ph.D.,

(Continued on page 18A)

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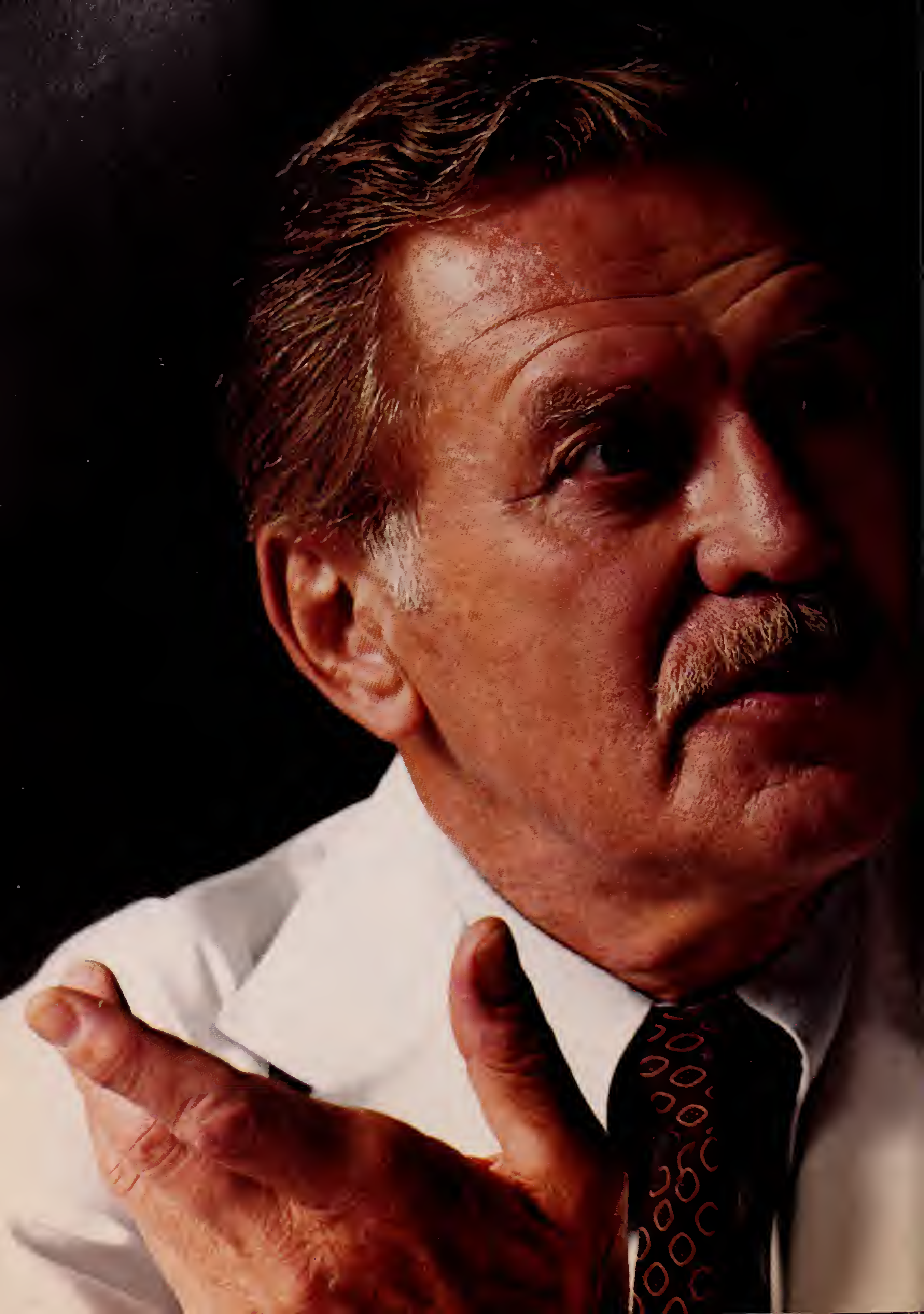

"When it comes to cardiovascular medicine, I like to know exactly what my patients are swallowing."

There are doctors who say that generic drugs have a place in their practice—but not necessarily in the treatment of serious or potentially life-threatening disease. And when they consider that the average patient pays only about 45¢ a day for INDERAL (propranolol HCl) Tablets, there's not much left to discuss.

When it's INDERAL Tablets you want for the treatment of hypertension, angina, arrhythmias, or post-MI patients, make sure you specify "Dispense As Written" (DAW), "Do Not Substitute," or whatever is required in your State. That way, you'll know exactly what your patients will get.

Please see next page for brief summary of prescribing information.

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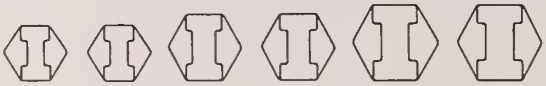

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION. SEE PACKAGE CIRCULAR)

INDERAL® (propranolol hydrochloride) Tablets

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block 3) bronchial asthma 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE continued use of beta blockers can, in some cases, lead to cardiac failure Therefore at the first sign or symptom of heart failure the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and in some cases myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME several cases have been reported in which, after propranolol the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS

General Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting epigastric distress, abdominal cramping diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Immanuel Medical Center

Announcing . . .

ALCOHOLISM/CHEMICAL DEPENDENCY FELLOWSHIP PROGRAM, May 3, 1985

A day-long continuing education program in Alcoholism and Chemical Dependency for primary care physicians will be held at the Holling Education Center, Immanuel Medical Center in Omaha on May 3, 1985. This program is designed to enhance physicians' understanding of the diagnosis, treatment and follow-up of chemically dependent patients. Continuing Medical Education (CME) credits are offered for participation in the program.

For participants requiring overnight accomodations, lodging is available at the beautiful new Immanuel Plaza Motel on the Medical Center campus. Spouses are also welcome to accompany physicians attending the Fellowship and to enjoy a day of shopping and sightseeing in Omaha.

An agenda of the program is as follows:

7:30-8:10 a.m. - Breakfast	
8:10-8:15 a.m. - Welcome/Introduction	John J. Hoesing, M.D.
8:15-9:00 a.m. - Diagnosis of Alcoholism/ Chemical Dependency	John J. Hoesing, M.D. Richard K. Dyer, M.D. Pam Garrett, M.A., A.P.A.C.
9:00-10:00 a.m. - Intervention Process	James Mays, M.P.A., P.A.C.
10:15-11:15 a.m. - Detoxification	William A. Shiffermiller, M.D.
11:15-12:30 p.m. - Treatment Modalities	Christopher Eiel, M.A., P.A.C.
1:00-2:20 p.m. - Immanuel Medical Center ATC Treatment Process	Christopher Eiel, M.A., P.A.C. Terrence R. Finney, M.A., S.P.A.C. (Chaplain - to be announced)
2:30-4:00 p.m. - Aftercare	John J. Hoesing, M.D. Richard K. Dyer, M.D. Deborah Umberger, B.S., A.P.A.C. James Mays, M.P.A., P.A.C. AA Member
4:00-4:20 p.m. - Prevention	John J. Hoesing, M.D.

For more information on this or future Fellowships, contact Marion Kapie, Holling Education Center, Immanuel Medical Center, 6901 North 72nd Street, Omaha, Nebraska 68122, (402) 572-2340.

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WashingtoNotes

(Continued from page 12A)

said the freeze delays but does not deny the larger increases.

* * *

GAO Cites Government Lack in Medicaid Program

The Health and Human Services Department should issue regulations or use financial penalties to improve states' identification of Medicaid patients who also have private insurance or other coverage, according to the General Accounting Office.

A GAO report based on six state Medicaid programs confirmed an HHS estimate that Medicaid may be spending $500 million to $1 billion a year for medical care to Medicaid patients who have other coverage. But it

(Continued on page 27A)

"I'D LIKE TO MAKE AN APPOINTMENT WITH THE DOCTOR"
COLORECTAL CANCER

Be prepared, Doctor. More patients will be asking about colorectal cancer. According to a survey* conducted by the American Cancer Society, many people would like to receive more information about colorectal cancer, and 83% said they would want to be checked for it. Further, they are learning that this cancer can be detected *before* symptoms appear. The present cure rate is 44%. The cure rate *could* be as high as 75%, with early detection and appropriate management.

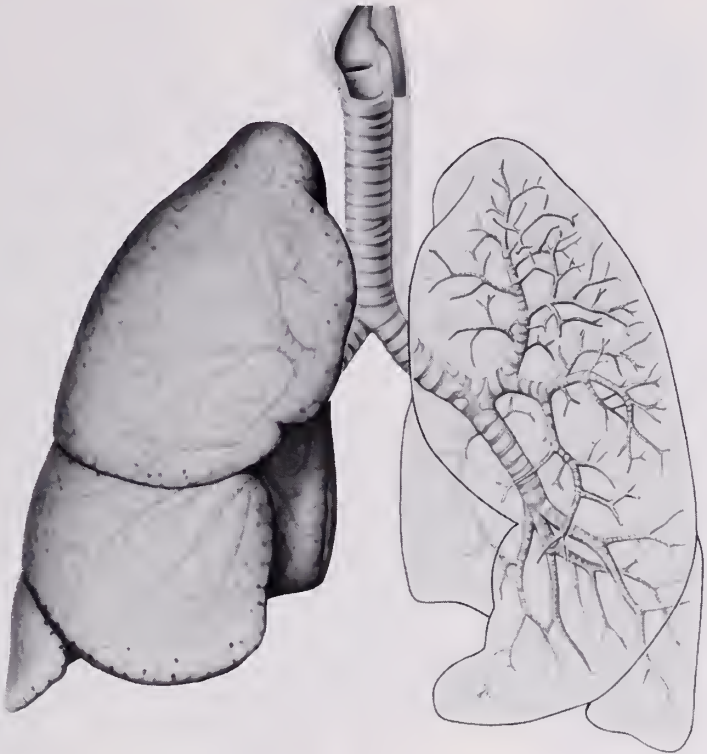
For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

AMERICAN CANCER SOCIETY®

*"Cancer of the Colon and Rectum: Summary of Public Attitude Survey," *Ca* 33:359-365, 1983 (Nov.-Dec.).

Consider the causative organisms...



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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

ief Summary Consult the package literature for prescribing ormation

dications and Usage Ceclor® (cefaclor, Lilly) is indicated in the eatment of the following infections when caused by susceptible rains of the designated microorganisms
Lower respiratory infections, including pneumonia caused by *reptococcus pneumoniae (Diplococcus pneumoniae), Haemoph-s influenzae* and *S pyogenes* (group A beta-hemolytic reptococci)
Appropriate culture and susceptibility studies should be rformed to determine susceptibility of the causative organism Ceclor

ntraindication Ceclor is contraindicated in patients with known ergy to the cephalosporin group of antibiotics

arnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALO-PORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY HERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL ROSS-ALLERGENICITY OF THE PENICILLINS AND THE EPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH ATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, BOTH DRUG CLASSES
Antibiotics, including Ceclor should be administered cautiously any patient who has demonstrated some form of allergy rticularly to drugs
Pseudomembranous colitis has been reported with virtually all oad-spectrum antibiotics (including macrolides, semisynthetic enicillins, and cephalosporins), therefore it is important to nsider its diagnosis in patients who develop diarrhea in sociation with the use of antibiotics Such colitis may range in verity from mild to life-threatening
Treatment with broad-spectrum antibiotics alters the normal ora of the colon and may permit overgrowth of clostridia Studies dicate that a toxin produced by *Clostridium difficile* is one imary cause of antibiotic-associated colitis
Mild cases of pseudomembranous colitis usually respond to ug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[0617B2R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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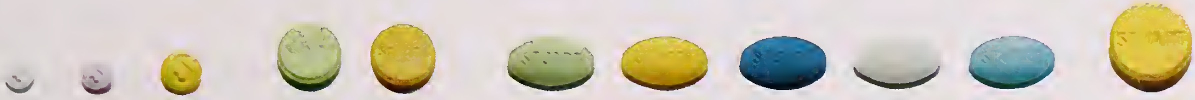

2.5 mg 5 mg 10 mg
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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg) Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2 5 to 5 mg, for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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WashingtoNotes

(Continued from page 18A)

maintained that HHS has not taken all the steps it could to improve state performance in this area. State and federal governments shared in the losses since the federal government contributes from 50% to 78% of total Medicaid spending per state.

In its investigation of Medicaid programs in California, Maryland, Oregon, Pennsylvania, Texas, and Washington, GAO identified several ways in which states could improve their procedures for identifying which Medicaid recipients have other coverage such as private health and auto insurance, workmen's compensation, or military health benefits.

One GAO recommendation would require health care providers to seek payment from other identified insurers before billing Medicaid. Others call on the states to ask Medicaid recipients more specific questions to identify possible insurance coverage beneficiaries may not even be aware of; to ask beneficiaries for the other insurers' name and the policy number; to compare Medicaid files with other data sets such as lists of state employees; and to screen claims such as for broken bones that might be associated with accidents covered by liability insurance.

For the federal government the report recommends two options: (1) strengthen regulations governing state recoveries of other insurance benefits; or (2) reduce federal Medicaid payments to states by the amount that federal officials could have been collected from other insurance programs.

HHS Inspector General Richard Kusserow responded that HHS is working with states to enhance Medicaid collections from other insurers. He claims that stiffer regulation of state collection efforts would not work unless they were associated with financial penalties which could not be imposed without new legislation.

* * *

THE NEBRASKA MEDICAL JOURNAL

What is the Problem - Chest or the Leg Wound?

DEEPAK M. GANGAHER, M.D.
Associate Editor, N.M.J.

FOR over a decade, coronary artery bypass surgery has been one of the most common operations performed in the United States. Even though chest wounds may appear more traumatic due to sawing of the sternum, a well-wired and immobile sternum is usually not a problem to the patient. Of course, big-built and heavy-chested individuals may complain of some soreness and pain due to sprained costovertebral ligaments and cracked ribs. But the majority of symptoms are related to the extremity from which the saphenous vein is harvested. In this issue of the Nebraska Medical Journal, Dr. DelCore and Dr. Preheim have very nicely touched on one of the complications i.e. cellulitis with dermatophyte infection that results in a phlebectomized extremity. It is not entirely clear how fungal infection in the web space of the foot in the vein donor extremity predisposes it to cellulitis. One of the hypothesis is that a break in the epidermis due to fungus infection acts as a "port-of-entry" for the bacteria. Since a phlebectomized leg has some venous and lymphatic insufficiency, it provides good media for bacterial growth. In a great majority of cases, streptococcus is the invading organism, although staphylococcus is also seen. Most of the time local wound and blood cultures are unrewarding. As these authors have discussed, treatment should be with oral or parenteral antibiotic agents, depending upon the severity of the clinical picture of the patient, plus topical use of anti-fungal agents. Some of these patients continue to have recurrent attacks of cellulitis. Some of the local and systemic manifestations may well be due to the direct toxic and immunological manifestations of streptococcal pyrogenic exotoxins, trichophytons, and locally present endotoxins in the extremity.

Some of the other wound related complications that are sometimes seen in the lower extremity post-coronary artery bypass are edema, hematoma-seroma, and saphenous nerve injury. One of the most common problems in a phlebectomized lower extremity is swelling of the foot and the leg. This edema is due to venous and lymphatic insufficiency. In the majority of the patients, ambulation and elevation of the extremity above the chest level relieves the swelling in a few weeks. Sitting with the feet hanging down is definitely an aggravating factor. Of course, the possibility of deep-vein thrombophlebitis should be considered.

At times, a hematoma or seroma develops right under or around the incision. If these are of small size, invariably these resolve spontaneously. Liquefied hematomas and seromas can very well be aspirated in the office. Of course, large hematomas are better off evacuated surgically before these get infected. Once hematomas and wounds get infected, one is better off at draining these abscesses early to allow healing by secondary intentions. Appropriate antibiotics should be used. If there is undermining of the tissues while harvesting the vein and a thin superficial flap is created, overlying skin gets devascularized and eschar forms. Once fully demarcated, it requires excision followed by, depending upon the size, possible skin grafting.

Another complication that is sometimes seen in a phlebectomized lower extremity is injury to the Saphenous nerve, as it runs parallel to the saphenous vein in the leg. It produces numbness, tingling, and burning and can be quite annoying to the patient. Most of the time it completely clears up in a few months.

ORIGINAL ARTICLES

Neonatal Group B Streptococcal Septicemia

A retrospective analysis of newborns with proven sepsis in 1983 at Saint Elizabeth Community Health Center was undertaken. The Neonatal Intensive Care Unit log and patient charts were examined. These records were cross-referenced with culture information provided by hospital infection control data. Maternal charts were reviewed for evidence of risk factors in those infants with verified septicemia.

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Results

The majority of intrapartum infections were recognized after delivery and none of the mothers were pretreated with antibiotics. At least one-half of the mothers developed ruptured membranes for longer than twelve hours, but the duration overall was quite variable. (Table 1)

Seven of eight infants were clinically judged to be premature but none of the infants were in the very low birth weight category (less than 1,000 grams). Of the ten documented cases of neonatal sepsis in our unit, eight of the cases were the result of Group B Strep, as represented in Table 2. Of the other two cases, one infant developed systemic candidiasis while the other infant had streptococcus mitis. The mother of the latter infant had purulent amnionitis with the same organism.

Interestingly, none of the infants had Apgar scores less than four. Seven out of eight infants developed some degree of respiratory distress during the first 48 hours of life. All infants had absolute granulocyte counts of less than 1500/cmm. at some point in time during the acute phase of their illness.

The urine latex agglutination test was positive in all cases tested. During the study period, we had two additional infants who had positive urine latex agglutination tests but did not have blood cultures positive for Group B Strep (GBS) nor clinical courses consistent with GBS; these two tests were considered false positive. Conversely, during the same study period we had no positive cultures for Group B Strep in infants who had negative urine latex agglutinations. Of great importance was the discovery that two of the eight infants with very mild respiratory distress, who had positive urine latex agglutination tests, initially had normal total white blood cell and differential counts.

Discussion

Epidemiology

Early onset GBS, occuring within the first five days of life, is two to three times more

TABLE I. FACTORS FOR MOTHERS OF INFANTS WITH GBS

Case Number	Single/ Twin Birth	Delivery	Weeks Gestation	Membranes Ruptured	WBC @ Delivery	Intrapart. Infection	Pre-Treatment W/Antibiotics
1	Single	Vaginal	35	16 hr.	11.9	No	No
2	Twin	C/B	36	18 hr.	6.9	Yes	No
3	Single	Vaginal	36	7 hr.	10.1	No	No
4	Twin	Vaginal	34	At Birth	--	No	No
5	Single	Vaginal	34	? 6 Days	18.8	Yes	No
6	Single	Vaginal	39	13 hr.	9.5	Yes	No
7	Single	C/B	35	At Birth	11.3	Yes	No
8	Single	Vaginal	33	24 hr.	9.2	Yes	No

common than late onset.[1] Attack rates of 1-4/1000 live births have been reported,[2] making the 1.6/1000 live births for Saint Elizabeth Hospital comparable. This review suggests that while GBS has been steadily increasing in incidence, there has been a noted decrease in incidence of the cases of sepsis due to gram negative organisms, in contrast to Baker and others.[3]

There are six sub-types of GBS: Ia, Ib, Ic, II, III, and a group which is not-typable. The principle reservior for GBS is the female genital tract, with a colonization rate of approximately 40% in the midwest, according to John Fishburn, M.D.[4] This may be higher than the national average.[5] Genital colonization of the male urethra is also common, although this may be intermittent.[6] Only a small percentage of the mothers who have positive vaginal cultures for GBS deliver infants who clinically exhibit signs of illness.

Risk Factors

Early onset GBS has been associated with several risk factors, and prematurity may be the most important. Generally, the lower the birth weight, the higher the incidence of GBS, and the greater the mortality. Two other major risk factors are premature rupture of the placental membranes and overt maternal intrapartum or postpartum infection (fever).

Another factor associated with GBS is a lack of type-specific antibody, which is important for phagocytosis and clearance of GBS from the host. The quantity of type-specific antibody transmitted to the fetus generally increases with increasing gestational age. Quantitation of vaginal colonization suggests that the extent of maternal infection affects the rate of transmission from mother to neonate.[7]

Prevention

At the present time, the development of active immunization of child bearing women to produce type-specific IgG antibody and the development of intravenous human immunoglobin preparation to provide opsonization by antibody to GBS offers the greatest hope for prevention. These, at best, are only in the experimental stages of development. Current technolgoy does not permit routine screening of pregnant women for immunologic suseptibility to GBS infection, although the development of sensitive automated systems such as ELISA[8] may make such screening possible in the future.

A study by Yow, et al., showed that when normal parturient women colonized with GBS were treated with intravenous ampicillin, sig-

TABLE II. FACTORS OF INFANTS WITH GBS

case Number	Weeks Gestation	Weight In Grams	Apgars	Presenting Sign/Symptom	Urine Latex Aggl.	Hypotension	Hypercarbia	WBC/Absolute Granulocyte (tho/cmm)	Culture Site	Culture Result	Lived/ Expired
1	35	2440	7-9	↑ respirations retracting dusky	+	no	briefly	3000/1380	blood CSF	pos. neg.	lived
2	36	2350	5-8	↑ respirations dusky	+	yes	no	2400/72	blood CSF	pos. neg.	expired
3	36	2700	8-8	↑ respirations retracting grunty Seizure	not done	yes	no	5200/156	blood	pos.	expired
4	34	2010	4-7	grunty retracting	not done	yes	briefly	2000/260	blood	pos.	expired
5	34	2150	7-9	↑ respirations retracting grunty	+	no	no	3900/1460	blood	pos.	lived
6	39	3460	5-9	↑ respirations grunty dusky	+	no	no	2600/806	blood CSF	pos. neg.	lived
7	35	2723	-	irritable flaccid	+	no	no	4400/1400	blood CSF	pos. neg.	lived
8	33	1825	7-9	↑ respirations grunty retracting	+	no	yes	2200/1122	blood	pos.	lived

nificant antibiotic levels were achieved in amniotic fluid and in cord blood samples. As a result, vaginal colonization was markedly diminished and neonatal colonization was significantly reduced. However, a few infants whose mothers were treated with intravenous ampicillin have developed GBS sepsis.[9]

Latex agglutination test of urine

The use of antigen antibody test for GBS allows for rapid identification of GBS (30 minutes) on a small voided urine sample. The Wellcogen® latex slide agglutination is one such test that:

1. contains a negative control agent and a positive control antigen.
2. requires heating of urine to remove non-specific agglutination.
3. predictive value of a positive result is 80%.[11]
4. occasional false positive reactions may be due to L-rhamnose (cell wall component), the principle carbohydrate in the GBS polysaccharide antigen, which is present in other bacteria including Group G Streptococcus.[12]
5. costs are comparable for urine agglutination tests presently on the market.

It is known that post treatment blood cultures in infants with GBS may be negative while GBS is found in the lungs of those infants at autopsy. A mother treated with intravenous ampicillin can deliver an infant who is culture negative but harbors GBS in the lungs.[10] A positive latex agglutination for GBS is such an infant with a negative blood and/or cerebral spinal fluid culture should justify continuation of antibiotic therapy at the discretion of the physician.

Summary

Although the population base and time period for this review are restrictive, it appears that the incidence of gram negative septicemia is decreasing as GBS sepsis increases.

Infants with GBS may have very mild symptoms of respiratory distress, or none at all initially. Therefore, the following recommendations are proposed:

1. Infants of mothers presenting with the ensuing obstetrical risk factors should have a urine latex agglutination test:
    A. premature rupture of membrane (>24 hours)
    B. intrapartum maternal infection
    C. previous infant with GBS sepsis
2. All infants, regardless of gestational age, who have respiratory distress symptomatology should have a urine latex agglutination test, CBC with differential, and blood (and possibly CSF) cultures.
3. It may not be cost effective to have the urine agglutination test available in all community hospitals; therefore, practicing physicians need to work out the arrangements for testing with the hospitals' consulting pathologist.
4. All infants with a positive urine latex agglutination test should have additional evaluation and treatment at a facility which routinely cares for sick newborns.

Acknowledgement

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Case Report: Cellulitis Associated with Dermatophyte Infection in the Vein-donor-leg of a Coronary Artery Bypass Patient

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CORONARY artery bypass graft (CABG) surgery is a common therapeutic approach for patients with coronary artery disease. The exact incidence of CABG procedures performed in Nebraska is unknown, but approximately 160,000 CABG operations were performed nationally in 1981.[1] Post surgical follow-up, especially for patients from rural communities, will often be provided by the patient's primary physician. It is for this reason that the following case is described and illustrated.

Case Report

A fifty three year old white male was admitted to the hospital in May, 1984, for an acute onset of fever, chills, and pain in his right thigh beginning the day of admission. He underwent the last of four CABG procedures in March, 1983. Physical examination was remarkable for a temperature of 101.4°F, tenderness in the medial aspect of the right thigh, a 2x3 cm. palpable and tender inguinal node on the right, and an area of erythema on the anterior tibial surface that was tender and hot to touch. This area was superimposed on a site of previous vein-graft-harvesting (Figure 1). There were no palpable cords and no ulcers. The patient had erythema and scaling between the toes of the right foot, consistent with chronic tinea pedis.

His admission white blood cell count was 16,100/mm^3 with 70% segmented neutrophils, 19% bands, and 6% lymphocytes. Blood cultures were negative. The patient received intravenous penicillin G 1.2 million units every four hours, and showed rapid clinical improvement. Skin scrapings of the patient's right foot revealed hyphal elements suggestive of a dermatophyte.

After five days of intravenous therapy he was discharged on oral penicillin therapy for an additional nine days. The patient's tinea was treated with tolnafate (Tinactin). Follow-up one month later revealed resolution of both the cellulitis and the tinea.

Discussion

This case illustrates a recently described syndrome.[2-6] in which cellulitis occurs in the vein-harvested leg of a CABG patient. This cellulitis, which occurs in association with a *Trichophyton* infection of the foot, may be recurrent, especially if proper therapy is not instituted for both the cellulitis and the dermal infection.

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The patient, previously healthy, experienced an acute episode of cellulitis in his right leg where previous vein-graft-harvesting had occurred. The time interval between his last surgery and the onset of cellulitis was 14 months. The exact onset of the dermal infection was not known but had been present for several months. Review of previously reported cases revealed that the cellulitis may occur two months and up to eight years after surgery.[2-4] In one series of nine patients, the mean interval was 15 months.[3]

In this syndrome the clinical picture of cellulitis has the appearance of a tender, erythematous area overlying a phlebectomy scar. Fever, chills, and malaise may occur but may not be reliable signs.[7] A mild leukocytosis may be present. As in this patient, lymphangitis may cause palpable tenderness along channels in the leg. Subsequent lymphadenitis can cause tender inguinal adenopathy.

Wound cultures were not obtained, and blood cultures were negative in this patient. However, his clinical course and response to penicillin suggests cellulitis caused by group A *Streptococcus.* The two most common bacteria causing cellulitis are group A *Streptococcus* and *Staphylococcus aureus.*[8] In previously reported cases of cellulitis following CABG, *Streptococcus* was most commonly implicated.[2-4] In one case *Streptococcus* was isolated from the lesion.[2] Needle aspiration of these soft tissue infections may be helpful in making the diagnosis,[9] although mechanisms other than direct bacterial invasion may be responsible.[2] Blood cultures are usually negative with streptococcal cellulitis, but bacterial invasion into the blood stream may occur. Isolated cases of bacteremia have been reported in this setting.[3,5-6] Streptococcal cellulitis can develop into a life-threatening illness and has been reported to cause circulatory collapse requiring inotropic support.[10]

Tinea pedis or "athlete's foot" was found in our patient. It has been described in most, but not all, CABG patients who developed cellulitis. The association between streptococcal infections and dermatophyte infections is well known.[11-12] Fungal infections of the skin may facilitate entry of the streptococcal organism.[13]

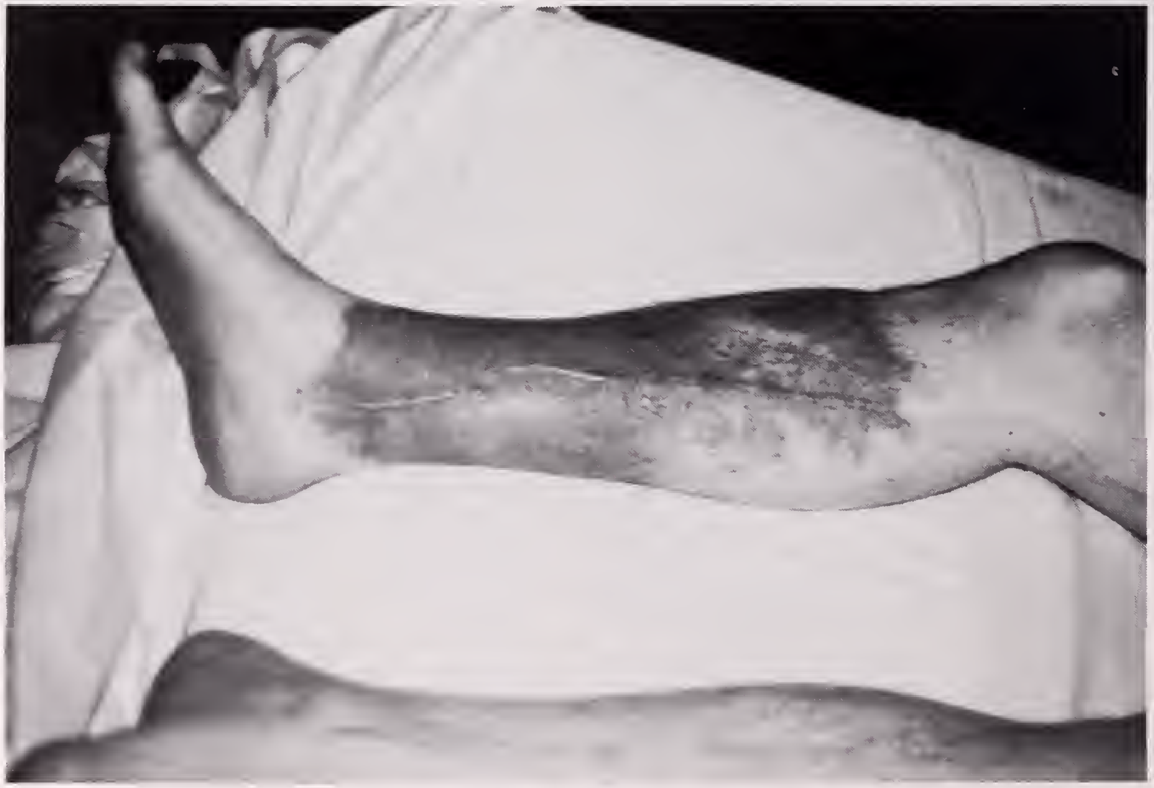

Figure 1
Cellulitis of right leg involving saphenous vein harvesting site.

Impaired venous and lymphatic drainage in a limb, such as occurs in venectomy patients, is associated with a higher incidence of infections.[14] Therefore, a number of seemingly unrelated factors may play a role in the development of this syndrome.

Therapy for CABG patients who manifest cellulitis associated with tinea is two-fold. First, the acute attack of cellulitis should be treated with an appropriate antibiotic, usually a penicillin. Then a careful search should be made for an underlying skin condition associated with breakdown of the dermis, such as tinea. If tinea pedis is found, topical therapy with an antifungal agent is indicated to reduce the risk of recurrence.

Cellulitis in a bypass patient associated with a fungal infection is an easily recognized syndrome. Increased awareness of this syndrome among primary care physicians may lead to more prompt diagnosis and treatment.

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The Importance of Quality in Mammography

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THE value of mammography in detection of breast cancer in both symptomatic and asymptomatic women is no longer an issue of dispute. It's maximum benefit is achieved when utilized in the screening for the silent cancer. The average woman has a 7 percent chance of developing breast cancer in her lifetime. Each year in the United States, 70,000 new cases are diagnosed and nearly 30,000 women die of this disease.[1] Potential curability of breast cancer resides largely in the premise that dissemination and incurability of disease are directly related to the duration and size of the lesion.[2] In general, the earlier the cancer is detected and treated, the better is the prognosis. Long term (20 years) survival rates now exceed 95 percent for "early breast cancers", meaning those cancers that are 1 cm. or less in size at the time of detection.[3]

The Need To Find Early Cancer

How do we find the small cancer, those 1 cm. in size or less, that demand detection? X-ray mammography is the only imaging method suitable for screening asymptomatic women with proven cabability of detecting nonpalpable, clinically occult, early stage breast cancer.[4] For the purpose of mass screening, other imaging methods should be considered ineffective and experimental at this time.

Whether the low dose radiation utilized in current mammography techniques can cause breast cancer is unknown. "The risk, if it does exist, is so small that it has never been observed".[5,6] Possible existence of radiation induced breast cancer has only been inferred from excess incidence seen in women exposed to extremely high radiation doses. Well known, however, is evidence of a significant benefit from mammographic screening based on data from the trial studies (HIP) in New York of the 1960's, and more recently the NCI-ACS sponsored Breast Cancer Detection Demonstration Project (BCDDP). These studies also clearly indicate the need for the state of the art mammography and quality interpretive expertise. The BCDDP demonstrated that nearly 50 percent of the breast cancers were found in women below 50 by mammography alone. Thirty-six percent of these were minimal, early breast cancers, likely to have over 90 percent 20 year survivial rates.[7]

Mammography Superiority To Other Imaging Modalities

Investigators continue to pursue new and better methods of breast imaging but none today have clearly demonstrated the ability to identify Stage 0 and Stage I disease with the efficiency even close to mammography. While quality mammographic practice has clearly demonstrated its usefulness for early stage breast cancer detection, other imaging tools remain inefficient for screening application. Ultrasonography, for example, using high frequency sound waves, has the ability to distinguish cystic from solid masses but cannot, with standard available equipment, satisfactorily demonstrate the minimal cancer that demands detection. Ultrasound should be utilized in adjuntive roles to physical examination and mammographic studies.

Thermography, creating a "thermal map", while able to detect breast cancers, lacks specificity in early stage of disease. To date, computerized tomography has not demonstrated acceptability. The new MRI modality deserves a trial but it would appear to be insensitive to the earliest calcium deposition process that must be screened.

Light scanning techniques have not demonstrated sensitivity to the clinically occult carcinoma.[8] "Early" breast cancer detection techniques other than mammography are well reviewed by Kopans.[4]

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Technical Considerations

Mammography demands a close interaction of interpreter expertise and technical factors. The benefits of mammography decrease precipitously with a suboptimal examination.[9,10,11,12] Three parts comprise high quality mammography: **equipment, technologist** and **interpreter.**

Equipment - The single most important technical necessity for high quality film mammography is a dedicated mammography unit.[11,12,13] The primary reasons for this are breast compression, low kilovoltage x-rays for soft tissue contrast, and good resolution (small tube focal spot). Other features include proper beam filtration, grids, accurate positioning, and in some cases magnification.[13] Figure 1 exemplifies the difference in quality between a dedicated unit and "regular" radiographic equipment.

Technologist - The need for a qualified experienced and at least partially dedicated x-ray technologist cannot be overemphasized. Positioning, exposure techniques, and communication with the patient and radiologist are crucial.[13,14] A dedicated x-ray unit will not compensate for a poorly trained technologist.

Interpreter - Interpretation is usually performed by a radiologist. Quality work necessitates extensive experience and special interest in mammography. Quality control should be monitored closely.

Film Versus Xeromammography

Film screening mammography utilizes a special film and screen combination for low radiation and high detail. Xeromammography uses x-ray in a similar fashion but records images on an ionized special metallic plate. There are relative advantages to each; however, most agree that both are satisfactory for mammography using the guidelines indicated above.[9,10,15] A significant advantage of film/screen mammography is reduced radiation.[12,13,15,16,17,18] Xeromammography does not require dedicated radiographic equipment. It does however, require specialized developing equipment which costs about the same as a dedicated x-ray unit.

Clinical Experience

At our institution, we have been extremely pleased with the film/screen imaging modality. Radiation doses are extremely low, averaging 60 MR at midbreast for two views. Utilizing a dedicated mammography unit, we have brought to our patients the opportunity to subscribe to the American Cancer Society guidelines for breast cancer early detection.

Accordingly, mammography in our referral area has been significantly expanded. Due to increased number of patients undergoing screening, the cost of mammography has been significantly reduced. This places mammography in a more effective screening setting.

The American Cancer Society Guidelines for utilization of screening mammography are as follows: (1) The first or baseline mammogram should be obtained between age 35 and 40. (2) Subsequent mammographic examinations should be performed at 1 to 2 year intervals, determined by the combined analysis of physical and mammographic findings and other risk factors, unless medically indicated sooner. Primary family history of breast cancer, nulliparity or first childbirth after age 30 are known risk factor considerations. (3) Annual mammography and physical examinations are recommended for all women over age 50.[19]

Conclusion

Screening mammography has proven its ability to lower breast cancer death rates. Mammography must be practiced with meticulous attention to detail using the most modern x-ray equipment to maximize image information. Only in this environment do we do justice to our patients in the ongoing struggle against the leading cause of cancer death in women.

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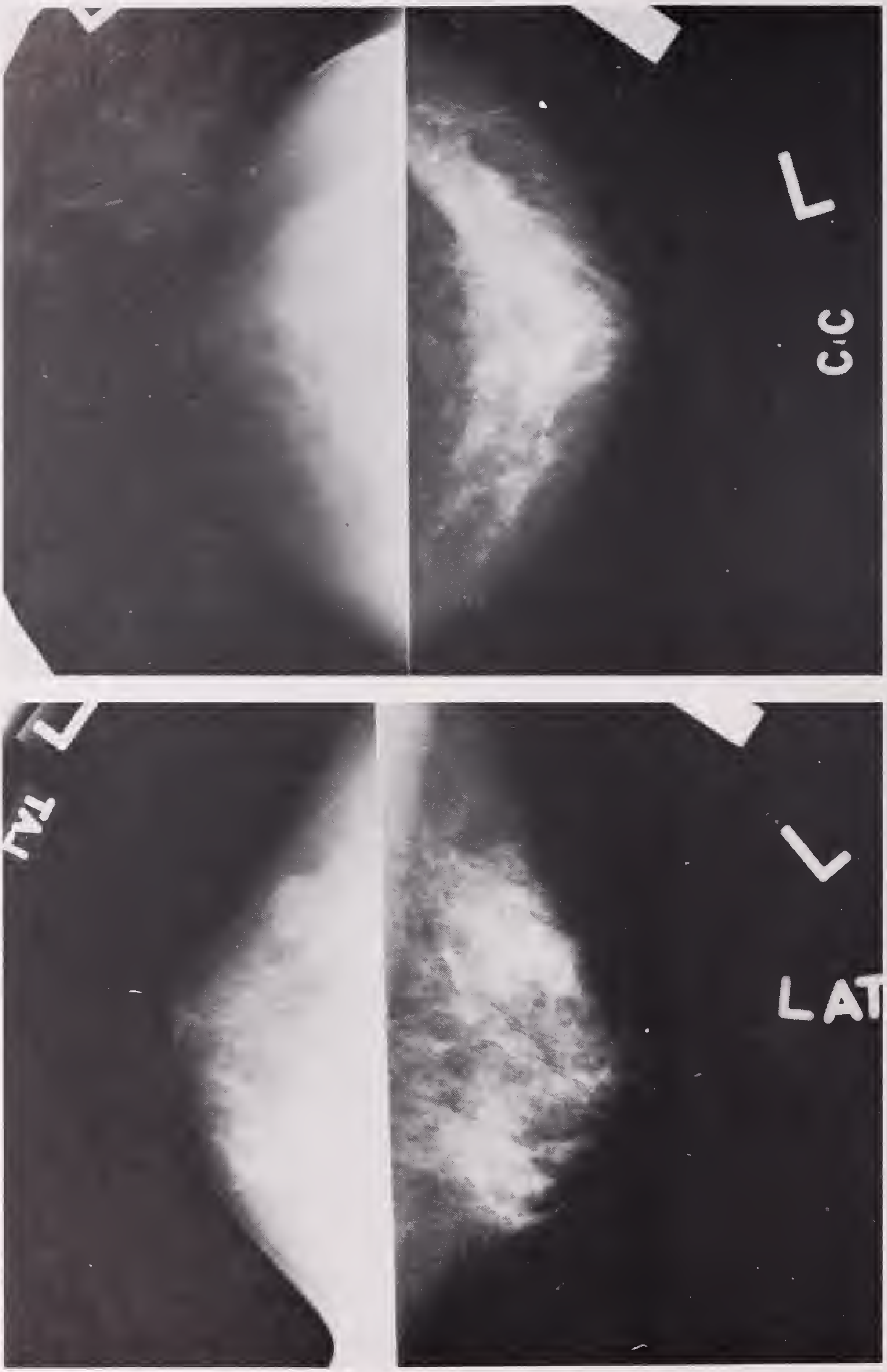

Figure 1, A and B. Image 1 (left) of A and B represents the same patient and same view as image 2 (right). Image 1 was performed with a non-dedicated radiographic unit while image 2 was performed with a dedicated mammographic unit. The improved detail and tissue contrast of image 2 is readily apparent.

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Complications of Mandibular Fractures:
A Retrospective Review of 100 Fractures in 56 Patients

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MANDIBULAR fractures are the second most common fracture of the facial bones, second only to fractures of the nasal complex, and complications are common. To review these complications, a ten year retrospective study was completed on patients treated for fractures of the mandible by the Department of Otolaryngology - Head and Neck Surgery at the University of Nebraska Medical Center. The review consisted of 56 patients with a total of 100 fractures. Mandibular fractures caused by gunshot wounds were excluded from the study. The study group included 48 males and 8 females. The mean age was 25 years with the range being from 4 to 74 years. Patients who had no other trauma required a median hospital stay of 4 days.

Types of Fractures

The overwhelming majority of the mandibular fractures were the result of blows to the face sustained in fights. Other mechanisms included motorvehicle accidents, machinery accidents and falls. Of the 56 patients, 22 had solitary fractures (39%) and 34 had multiple fracutres (61%). Of these multiple fractures, four were comminuted. The most common site of fracture was in the region of the angle of the mandible (27%). The other sites of fracture were: region of the body of the mandible (24%), parasymphyseal region (19%), condylar region (16%), ramus (13%), and coronoid process (1%). (Figure 1)

Treatment Modalities

Intermaxillary fixation has been the mainstay in the immobilization of closed mandibular fractures[1,2] and is an integral component of open reduction utilizing wiring and bone plates. Treatment of the 100 fractures included closed reduction with intermaxillary fixation in 56 fractures (Fig. 2). Open reduction and internal fixation was used in 42 fractures. Stabilization of fractures reduced by an open technique were maintained by wires in 26 fractures (Fig. 3) and by bone plates in 16 fractures (Figure 4). Two patients were initially stabilized utilizing external pin fixation.

Complications

Since the teeth are held together by either wire or elastic bands in intermaxillary fixation the most feared problem is aspiration secondary to vomiting. This complication did not occur in our patient review. However, eight patients were unable to complete the course of intermaxillary fixation because they prematurely released themselves from fixation. Of these eight patients, only one had any subsequent complication. This patient, a schizophrenic, developed a malocclusion and refused further treatment.

Complications of mandibular fractures occurred in 15 patients (26.8%) and in 16% of the 100 fractures. One patient suffered a severe arytenoiditis secondary to intubation for general anesthesia, but this anesthetic complication was not included in these numbers. The complications included: 1) soft tissue infection in nine patients (16.1%), 2) wound dehiscence with extrusion of bony sequestrum in two patients (3.6%), 3) malocclusion in two patients (3.6%), 4) mental nerve paresthesia (1.8%), 5) facial nerve damage (1.8%), and 6) bony nonunion (1.8%) in one patient each. (Table I)

A. Infection

Of the nine patients who developed an infection, six were receiving antibiotics at the time the infection appeared and three were not on antibiotic prophylaxis. One of these pa-

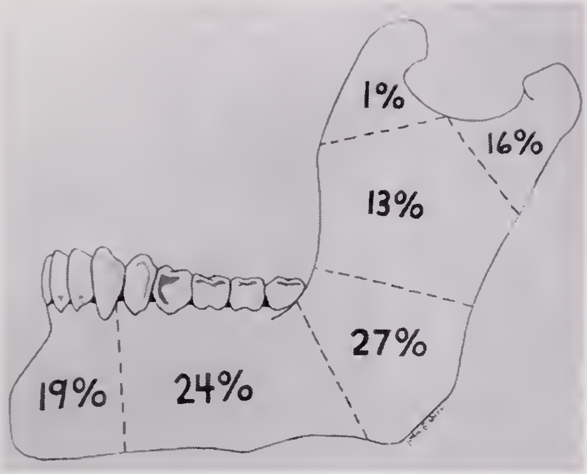

Figure 1.
Mandibular fracture location based on retrospective study of 100 consecutive fractures.

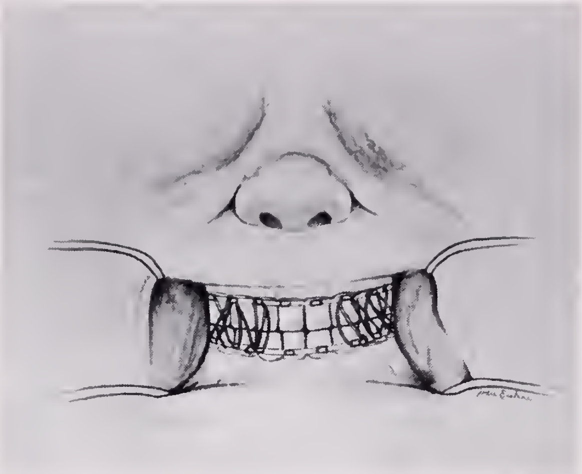

Figure 2.
Intermaxillary fixation (closed reduction) maintained by Erich arch bars and elastic bands.

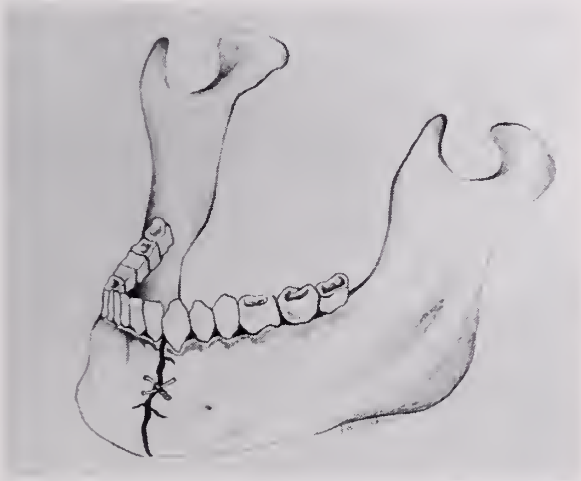

Figure 3.
Figure of eight wiring used to stabilize fracture in conjunction with intermaxillary fixation.

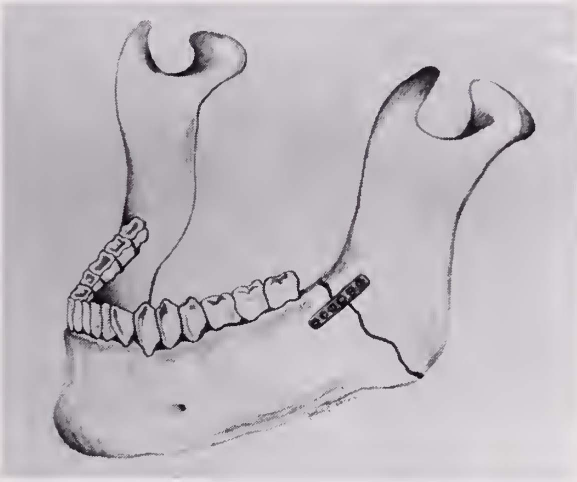

Figure 4.
Bone plate used to maintain fracture fixation in conjunction with intermaxillary fixation.

tients who received prophylaxis had a preexisting periapical abscess. The prophylactic antibiotics received by the six patients who developed infections were: Penicillin G in three patients, and Dicloxacillin, Keflin and Erythromycin each in one patient.

Six infections occurred in patients that required open reduction and internal fixation. Of these six, one had a periapical abscess at the site of fracture prior to surgery, one patient was not placed on prophylactic antibiotics at the time of the operation, and one patient developed his infection after the removal of circumandibular wires for a splint and was not on antibiotics at that time. Despite prophylactic antibiotics, three patients undergoing open reduction developed an infection; one bone plate was removed secondary to an infection in this last group. Three patients were treated with closed reduction by means of intermaxillary fixation and developed an infection. Of these three, two had fractures extending through a tooth socket and the other had an intraoral open fracture.

The two methods of open reduction and internal fixation utilized were direct wiring and bone plating. Two wound infections occurred in patients whose fractures were stabilized with direct wiring. This represents an infection rate of 7.7%. Two fractures reduced with bone plates developed infection and one of these plates required removal. This represents an infection rate of 12.5% in fractures receiving bone plate fixation. If the patient with the pre-existing periapical abscess is excluded, the overall infection rate for open reduction and fixation of mandibular fractures in the 42 patients is 9.8%, which compares favorably with the 8.9% infection rate obtained in closed reduction utilizing intermaxillary fixation only. (Table II)

TABLE I
Complications of Reduced Mandibular Fractures

Complication	Number	% of Total Fractures	% of Total Patients
Infection	9	9%	16.1%
Dehiscence	2	2%	3.6%
Malocclusion	2	2%	3.6%
Paresthesia	1	1%	1.8%
Non-Union	1	1%	1.8%
Facial Nerve Paralysis	1	1%	1.8%
Total	16	16%	26.8%

TABLE II
Methods Used for Open Reduction and Internal Fixation

Method	Number of Fractures	% of Open Reductions	Infections	Infection Rate
Wire Fixation	26	62%	2	7.7%
Bone Plate	16	38%	2	12.5%
Total	42	100%	4	9.8%

B. Dehiscence

Two patients (2%) suffered wound dehiscence that promptly healed after bony sequestra were removed.

C. Malocclusion

Malocclusion occurred in two patients (2%). One patient prematurely removed his intermaxillary fixation wires at 22 days; malocclusion resulted and he refused further treatment. The other patient had a fracture of the condyle and the parasymphseal region. The parasymphyseal fracture was treated with a bone plate and she was placed in intermaxillary fixation for six weeks. Upon release of the fixation, an open bite deformity had developed. She was placed back in fixation for 14 more days, and healed without further occlusal problems.

D. Nerve Injury

Mandibular fractures frequently cause injury to the inferior alveolar nerve resulting in paresthesia. It can also be damaged during the placement of internal fixation wires or screws. Mental nerve paresthesia occurred in one patient after a bone plate was placed on an angle fracture. This paresthesia resolved several months postoperatively without treatment.

The marginal mandibular branch of the facial nerve is at risk to be damaged during extraoral open reductions of the mandible. Statistically, it is most frequently injured during extraoral open reductions of the ramus and the angle.[3] In our study, one patient (1%) sustained damage to the marginal mandibular nerve during an extraoral open reduction of a fracture in the parasymphyseal region. Postoperatively, she was noted to have an inability to depress the angle of her mouth on one side. It is uncertain whether this resolved because she was lost to follow-up several months postoperatively.

D. Non-union

Bony non-union was found in only one patient (1%) in our review. This 74 year old patient was edentulous with an atrophic mandible and suffered bilateral body fractures.. The initial treatment consisted of closed reduction with the placement of a Gunning splint. This treatment had failed at six weeks. Subsequent open reduction and internal fixation with wires also failed. Final repair of the fracture was accomplished utilizing bone grafting.

Discussion

Our results are comparable to a study done by Chuong, et al, in his review of 372 mandibular fractures.[3] He reported a complication rate of: infections 1.9%, dehiscence in 1.6%, malocclusion 3%, facial nerve injury in 0.8%, and delayed union in 3.1%. Other authors have reported similar complication rates with higher rates of infection than those reported by Chuong.[4,5,6]

Infection was the most common complication in our study of mandibular fractures.

Three of our nine infections developed in patients not receiving prophylactic antibiotics and one of the remaining six had a pre-existing dental infection. Thus, an overall infection rate of 5% is calculated for those patients receiving prophylactic antibiotics and not having dental infection at the time of fracture. Considering that many of the fractures are open and the patient population included many indigents with poor oral hygiene and dentition, these results are consistent with previous reports.

The majority of the fractures occurred in the angle, body and parasymphaseal regions. Fractures here frequently involve a tooth socket which weakens the bony strength of the mandible. These fractures should be considered contaminated intraorally and for this reason, proper prophylactic antibiotic coverage should be implemented. Penicillin is the accepted drug of choice. Aqueous Penicillin G, four to six million units per day in divided doses, should be given parenterally in the preoperative period and continue for 48 hours postoperatively.[3] Oral Penicillin is then given for five to seven days. Erythromycin, 250 mg. to 500 mg. every 6 hours, can be given to patients allergic to Penicillin. Due to the diverse flora of the mouth, all infections cannot be prevented with these antibiotics. One author found that the majority of the organisms cultured from infections in patients with mandibular fractures were, however, sensitive to Penicillin.[4]

Strict attention should be given to the care of postoperative wounds and close observation maintained for the early detection of infection. Immediate attention should be directed to all fractures reduced with wires or bone plates, since these materials act as foreign bodies.. If infection is detected, the wound should be opened and a drain placed to hopefully avoid the need of removing the metal prosthesis.

The treatment of fractures in elderly patients with edentulous mandibles is a difficult problem.[5] Bony non-union is the complication most likely to occur in these patients. Studies have commonly reported non-union rates of 20%.[5] The increased non-union may be related to a diminished vascular supply to the area and a decrease in surface area of the ends of the fracture.[5] Treatment of these fractures may require intermaxillary fixation for periods of eight weeks or longer. The nutritional status of these elderly patients must be closely followed during this prolonged mandibular immubolization; high calorie supplements are suggested.

Summary

The potential for complications secondary to mandibular fractures and their repair is relatively high. The overall complication rate in our retrospective study of 100 mandible fractures is 16% with soft tissue infection the most common complication. Prophylactic antibiotics, local wound care and close postoperative observation will help control the occurrance of serious complications, but do not eliminate the problem. Careful surgical technique can diminish the incidence of nerve trauma. Close approximation of the opposing sides of the fracture and appropriate mandible immobilization by means of intermaxillary fixation will help maintain a low incidence of mal-union.

It is encouraging that the infection rate with open reduction is not significantly more than that obtained with closed reduction. It appears that the metallic foreign body, whether it is a wire or bone plate, does not increase the infection rate. Dynamic compression plating is a technique of open reduction not requiring intermaxillary fixation, currently being utilized for fixation of edentulous fractures and unfavorably displaced fracture to decrease the incidence of mal-union. Hopefully, the infection rate can also be reduced by this technique secondary to more rigid fixation and an improved nutritional status of the patient. At the present time, more follow-up is required to determine if this is the case.

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FRACTURE OF THE MONTH

Vascular Injury Associated with a Posterior Elbow Dislocation

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Case Presentation:

A 19 year old Mexican-American man injured his right elbow in a fall. Upon presentation in an emergency room at another hospital, pain and swelling were noted about the right elbow and x-rays revealed a posterior dislocation. Pulses were thought to be palpable distally at the wrist. The patient was splinted and, at his request, transferred to a military hospital. Pronounced swelling in the right elbow, pallor of the right hand and absence of pulse were noted at the second hospital. Doppler exam also failed to elicit a pulse. The posterior elbow dislocation was reduced but pulses remained absent. The patient was then immediately transferred to the University of Nebraska Hospital were arteriography revealed complete occlusion of the brachial artery (Figure 1). The purpose of this presentation is to discuss the pitfalls in the recognition and management of this limb threatening complication.

Discussion:

Vascular damage produced by blunt trauma is twice as likely to pass unrecognized as it is with penetrating trauma. Too often the cause of ischemic signs and symptoms are attributed inappropriately to temporary arterial spasm. As a result of this, limb loss is considerably higher when the vascular injury is associated with skeletal trauma.[1,2] Arterial damage with blunt injuries of the type presented in this case require early diagnosis, expedient operation, and revascularization. Significant muscle and nerve function is lost after 4-6 hours of ischemia. For ideal results, arterial ischemic injury with blunt trauma must be recognized and treated with revascularization in less than 8 hours from the time of injury. Arterial ligation, although recommended in the past,[3] is no longer acceptable as treatment for most of these combined bone and vascular injuries.

The initial step in managing any fracture or dislocation about the elbow is to record the vascular and neurologic status distal to the injury. Although disruption of the brachial artery with closed dislocation in the elbow is infrequent,[3,4] any such injury should be assumed to have sustained vascular damage until proven otherwise. Furthermore, because of the risk of vascular insult from blunt trauma producing elbow fracture or dislocation, it is important to immobilize the limb in a splint rather than a circular cast to allow for swelling.

The main signs of arterial damage include pulsatile, progressive swelling, pain in the ischemic muscle compartments and an absent pulse, particularly when it is accompanied by signs of ischemia distally. The physician must also keep in mind that on initial examination, as in this case, a pulse may seem palpable. This can be due to three different mechanisms: 1) intimal disruption can cause an arterial thrombosis but transmit pulse for many hours subsequent to the injury until thrombosis becomes complete. 2) Retrograde flow via collateral circulation may also give a falsely positive distal pulse for a period of hours or even days (Figure 1). 3) Finally, compartment syndromes can cause significant muscle ischemia by impairing cellular perfusion but not affecting the peripheral pulse.

Repeated evaluation of circulatory status is mandatory with any injury such as a dislocation producing extensive swelling about the elbow or the knee. In doubtful cases the procedure of choice is angiography to diagnose arterial damage. However, this diagnostic

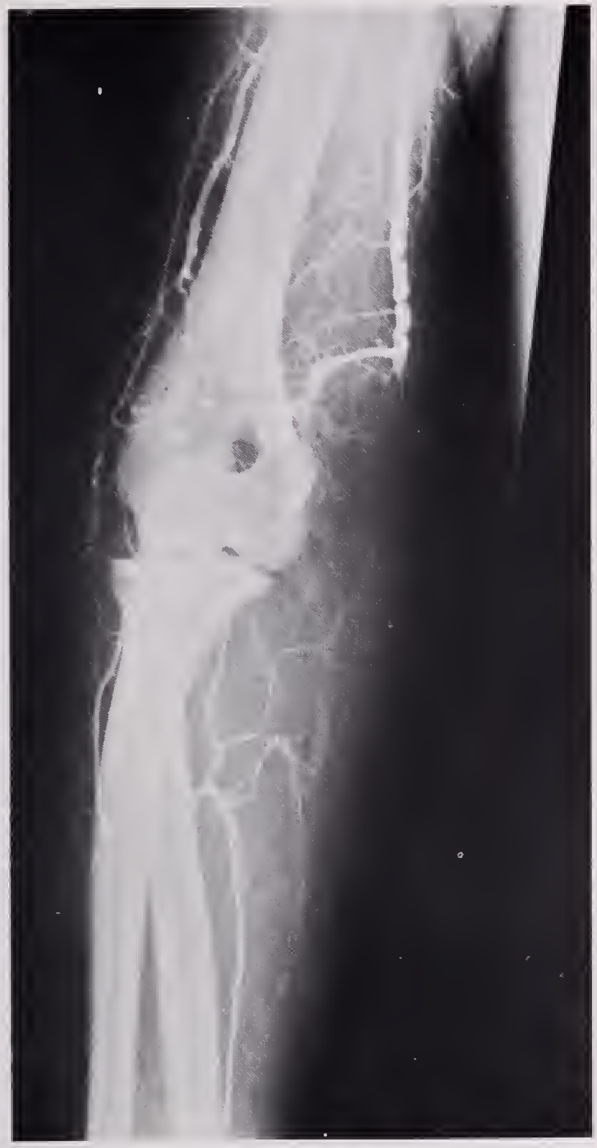

Figure 1: Arteriogram performed immediately prior to surgery revealed complete occlusion of the brachial artery with minimal collateral flow distally.

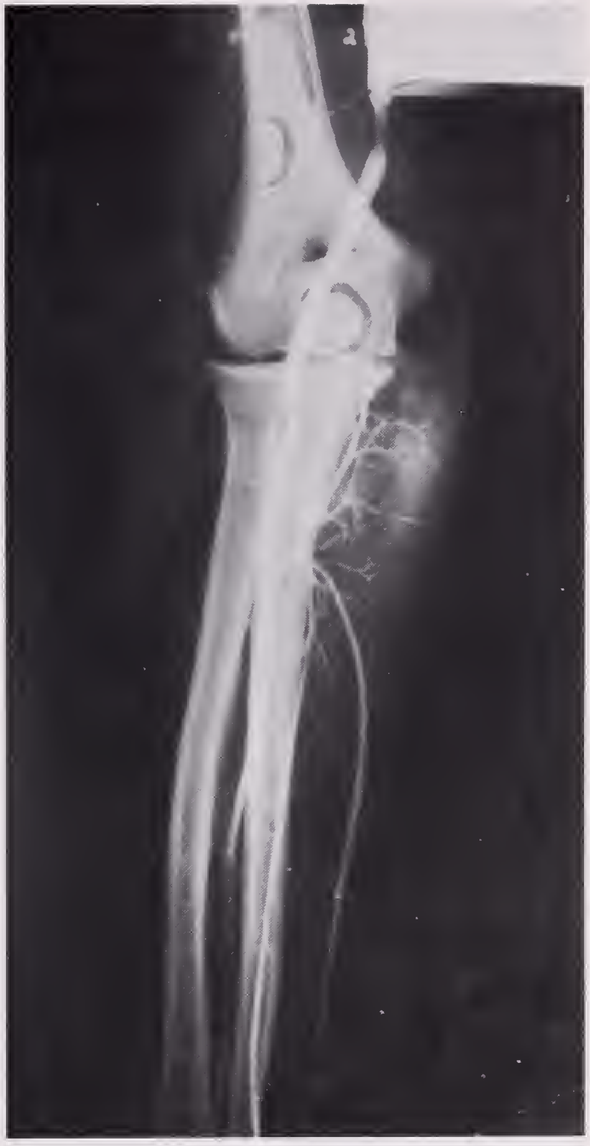

Figure 2: Arteriogram post repair of the brachial artery shows satisfactory flow through the main vascular channels.

procedure should not delay the appropriate surgical treatment when obvious vascular or other life-threatening injuries are evident. Indications for preoperative angiography include a high level of suspicion of an arterial injury, absent pulses, and obvious ischemia following penetrating wounds or multiple fractures in the same limb.

Once the vascular injury is diagnosed, the repair should be accomplished promptly by one of several techniques. These include resection of the damaged vessel with end to end anastomosis if the area of injury is small. Interpositional autogenous saphenous vein grafting is the second alternative if an end to end anastomosis can not be adequately performed. When there is a large amount of soft tissue or crushing injury, one should also be alert to the likelihood of a compartment syndrome. Complete fasciotomy should be performed if this is detected. Finally, functional rehabilitation of the involved limb must begin at an early post-operative stage for maximum results.

Management:

This patient was taken to the operating room and the antecubital fossa was explored following the arteriogram. The brachial vein was found to be lacerated and the brachial artery was thrombosed for 6 cm. The thrombosed artery was resected and an autogenous saphenous vein graft was interposed for the repair. Intra-operative angiography revealed good flow through the graft (Figure 2), although distal pulses could not be palpated. After a complete anterior fasciotomy of the forearm, distal pulses became palpable. The reduced elbow and forearm were immobilized in a posterior splint.

The patient's post-operative course was uneventful. Ten days postoperatively, he underwent split thickness skin graft to the fasciotomy site and soon thereafter began active elbow range of motion exercises. At follow-up one month post injury, the wounds were completely healed and the right elbow had 20-125° of flexion/extension with complete pronation and supination. At this time, the patient resumed his normal activities. Three months post injury the elbow lacked 10° of extension. X-rays of the elbow were normal.

This case illustrates well how arterial injuries produced by blunt trauma may not be recognized initially. The prudent policy is to assume that all such injuries, particularly blunt trauma to the elbow or knee where vessels are anatomically fixed, have sustained significant vascular injury until proven otherwise.

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SPECIAL ARTICLE

Recommendations and Medical Guidelines for the Use of Home Apnea Monitoring

**by Nebraska Chapter of the
American Academy of Pediatrics
Fetus & Newborn Committee**

The Fetus & Newborn Committee has been charged with developing guidelines for the use of home apnea monitoring. The initial guidelines from the committee were published in late 1983. This is an update or revision of those recommendations and consensus from the centers involved in home apnea monitoring.

Infants requiring home monitoring will be broken into three separate groups:

Group I is that group of infants in which a sibling died of SIDS. It is recognized that Group I infants rarely have a detectable apnea. It is felt, however, that these infants are at a higher risk for SIDS. However, current research questions whether the higher risk is limited only to a small percent of subsequent siblings. The evaluation and management of this group of infants is not clear; therefore, it is difficult for the Fetus & Newborn Committee to make absolute recommendations. We know, at present, that there is no means to predict which infants will die of SIDS, nor evidence to suggest how SIDS can be prevented.

Group III is that group of infants with Infantile Apnea or "Near Miss SIDS". Obviously these babies have detectable signs of apnea.

Group II is that group of infants with evidence of apnea in the neonatal period.

The committee realizes that there is a great deal of scientific study and research determining the cause(s) of SIDS. Depending upon these advances, there may be a rapid change in the Fetus & Newborn Committee recommendations for the use of home apnea monitoring. These are suggested guidelines in a very controversial area and are certainly not binding or absolute in determining the indications for home monitoring, as individual case variance may make major changes in the criteria.

Recommendations

I. GROUP I — (Sibling of SIDS)

A. Sibling of a SIDS
  1. All infants need to have cardiorespiratory surveillance during the neonatal period.
  2. If there are abnormalities during this monitoring period, all infants would be sent home on home apnea monitoring after proper infant evaluation, parent instruction and educational programs.
  3. If there are no detectable abnormalities during neonatal surveillance, then one of two courses seem appropriate depending on the physician and/or parenteral preference (B or C).

B. Selected home monitoring
  1. If the SIDS fatality was under two weeks of age, automatic home monitoring of the sibling should be carried out until pneumocardiograms at two weeks and two months are obtained and are normal, or other criteria outlined below are met.
  2. If the SIDS fatality was over two weeks, no home monitoring will be initiated unless a pneumocardiogram obtained at two weeks is abnormal, or if a pneumocardiogram obtained at two months (with the stress of the first DPT) is abnormal.

C. Home monitoring of all siblings of SIDS
  1. After parental education and instruction.
  2. Pneumocardiograms are to be obtained

at two weeks and again at two months (with the stress of the first DPT).

D. All twins, or multiple sibling births, of a SIDS victim automatically have a hospital evaluation, pneumocardiogram and home apnea monitoring after appropriate educational programs.

E. If there are two or more previous siblings with SIDS, then all subsequent babies would have some apnea monitoring after appropriate evaluation and educational programs.

II. GROUP II — (Infantile Apnea or "Near Miss SIDS")

A. All infants need hospitalization with a full investigative workup including a pneumocardiogram; 67% will be expected to have abnormalities on the pneumocardiogram and 33% will be normal.

B. An infant who has infantile apnea or a "Near Miss" episode will need home apnea monitoring after appropriate evaluation and education.

C. If the pneumocardiogram was normal and no other theories for the episode were found, then the infant should have a chemoreceptor study, or desaturation testing.

III. GROUP III — (Newborn infants and/or prematures **with** apnea)

A. Investigation for home apnea monitoring, including a pneumocardiogram, should be carried out if:
   1. The history of a previous sibling with SIDS, or a previous "Near Miss" sibling.
   2. Infant with a birth weight of less than 1200 grams.
   3. Infant with a gestational age of 32 weeks or less.
   4. Infant who requires continuous theophylline/caffeine therapy to ameliorate apnea and/or bradycardia, prior to discharge from hospital.
   5. Twins, or multiple birth siblings, of a premature found to have an abnormal pneumocardiogram.

B. Indications for absolute home apnea monitoring in neonates.
   1. Infants with persistent apnea and/or bradycardia that is not ameliorated with theophylline/caffeine therapeutic blood levels of the 10 to 16 range, prior to discharge from the hospital.
   2. Infants with bronchopulmonary dysplasia.
   3. Infants who have undergone tracheostomies.

The criteria for an abnormal pneumocardiogram at present are:

1. Any disorganized breathing pattern.
2. Apnea greater than fifteen seconds in a term and/or pre-term infant.
3. Excessive periodic breathing that is determined by gestational age and chronological age, or any single episode of periodic breathing recorded continuously and longer than two minutes duration.

Criteria for removing infants from the home apnea monitoring are:

1. A period of three months with no serious alarms requiring resuscitation.
2. There must have been two months where there were no alarms of significance.
3. There should be two normal pneumocardiograms off any medication with one of the pneumocardiograms obtained with the stress of a DPT or a URI.

Kenton L. Shaffer, M.D., F.A.A.P.

President's Page

"MEDICINE IN TRANSITION"

Resource Allocation — Rationing

The cost of returning to normal life with a disabling arthritic hip is $10,000, disabling refractory angina $20,000, and blindness with a cataract $3,000. There is a very large list exemplifying the remarkable advances brought about by the knowledge and technology of medicine, but all have been developed at a cost. There are many other advances projected in the immediate future to extend human life and its quality. With any other industry, such growth and breakthroughs would be considered a remarkable contribution to the economy of the nation. Not so with medicine. In fact, the rising health care costs have brought concerns just short of terror in many quarters. Congressmen are concerned as the medicare trust fund is headed for bankruptcy in the 1990's; the states struggle with increasing medicaid costs; and business loses its competitive position in the world economy due to health care costs. These continually rising costs overshadow the two main reasons for the escalation: an aging population and advancing technology.

Our population is getting older and will continue to age due to modern health care. Americans' life expectancy at birth has increased some thirty years since the 1900's; five of those years were gained in the last fifteen years. Americans' life expectancy was 74.5 years in 1983. There are thirty million people presently enrolled in Medicare, and by 2020 that figure will double. This simple fact alone contributes to at least one percentage point a year of the total annual increase in real costs. Another cost factor is advanced technology. Since World War II, medical knowledge and technology has produced an ever-changing and upgrading of the range and intensity of medical services. These developments improve longevity and quality of life but virtually always with a rise in costs. And, as we fully exploit technology, such as we are presently seeing with organ transplants and mechanical organs and implants, we will continue to see rising costs. These technological advances are the largest contributor to the rise in real costs.

Herbert E. Reese, M.D.

The only way to reduce the expenditure of health care resources effectively is to limit access to medical care, to limit the advancement of medical knowledge and technology, or to improve the efficiency of the delivery systems. Although improving the efficiency of the delivery system can have some impact on the high cost of medical care, this alternative is limited due to the aging population and continued technological advances. Most of the present schemes of cost control are centered around attempts to improve the efficiency of the system as the other alternatives have serious moral and ethical considerations. The government pro-competitive concept and prospective payment systems are designed to reduce expensive hospital care and admissions. If the most efficient system was in place today, we could save an estimated 11 million admissions with an annual savings up to 20 billion dollars. This is a savings of 5½ percent, at most, of total medical care expenditures. If physician income was halved, the reduction in expenditures would be less than 5 percent. If all the "fat" could be taken out of the system today, the savings would be, at best, 10 percent of present expenditures. It is not that efficiency should not be sought and that this won't offer some relief, but improved efficiency will not provide the long-term solution to the continued rise in real costs of medical care. For many reasons, we have seen some leveling off of health care expenditures in 1984. Margaret Heckler, Secretary of Health and Human Services, in the summer of 1984 announced that we had "broken the back of the health care inflation monster that has plagued us for two decades". This reassurance is short-term for after we cut the "fat", what then?

Many experts are talking in terms of "resource allocations". The meaning is clear: the inevitability of rationing and its form. Rationing presently is subtly occurring as expenditures outstrip resources. Many cost containment systems implicitly ration by resource allocation and limiting access. And as resources become more limited, there will be more rationing. Physician "gatekeepers" will become more prevalent and will have to consider economic realities in what actions to take on behalf of their patients. States with increasingly limited resources have had to cut benefits to Medicaid, institute co-payments, and move toward gatekeeper concepts. Hospitals with decreasing revenues will gradually move toward rationing with alteration of the standards of care in the interest of cost, discontinuing some services, and foregoing technological advancements. The health care system may soon become more multi-tiered than at present with the uninsured poor, currently about 12 percent of the population, suffering the most. As payors become more consumer-oriented rather than community-oriented, institutions will become rapidly less able to subsidize free care. The book titled the **Painful Prescription - Rationing Hospital Care** by Henry Aaron and William Schwartz from the Brookings Institution in Washington, D.C., describes with great clarity the topic of rationing health care. This authoritative book was developed from a thorough study of the British system and is an important reading for physicians.

Ultimately, experts argue limits must be set; we must define adequate health care in contrast to total health care. Many of these considerations are foreign to us as physicians. We do not base our practices on patients' ability to pay, nor do we choose what is best for our patients' welfare on the basis of cost. Our choices for patients have been based on strict clinical considerations and not on the basis of economic considerations that may affect the patient, the hospital, and society. Economic considerations in medical decisions will eventually lead to age, social uselessness, and ability to pay as a determinant which is irrelevant to the ethical practice of medicine. Society will have to make these hard decisions. No matter how efficient we make the system, we have to come back to face the issue that expenditures are outstripping the resources. What value are we willing to place on health and are we willing to commit to greater resources? If we are unwilling to do this, we must begin setting up the mechanism to make the terrible decisions of limited care. What is most important is that society must recognize that curtailment of resources places limitations on medical care that will be available.

Herbert E. Reese, M.D.

Coming Meetings

1985 ANNUAL SESSION — April 26-29 — Lincoln Cornhusker

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

UNIVERSITY OF NEBRASKA COLLEGE OF MECIDINE — ALPHA OMEGA ALPHA, AOA Day, Wednesday, April 24, 1985, UN Medical Center, Omaha, Nebr. Speaker: Robert D. Sparks, M.D., President, Chief Programming Officer, and Trustee, W. K. Kellogg Foundation, Battle Creek, Michigan. Convocation: 12 noon, Wittson Hall Amphitheater, UNMC Campus. Everyone welcome to attend. AOA Banquet: 6:00 p.m., Highland Country Club, Omaha.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSN. — Annual Business Meeting, Saturday, April 27, 1985, in conjunction with Nebraska Medical Association Meeting; 4:30 p.m. in Room F, Convention Center, Cornhusker Hotel, Lincoln. Alumni are urged to attend; spouses and guests are welcome.

TETON'S GENERAL PEDIATRIC CONFERENCE — June 30 - July 6, 1985. Sponsor: Department of Pediatrics, University of Nebraska College of Medicine. Location: Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 20 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Pediatric cardiology, gasteronterology, genetics, asthma, allergies and immunology, neonatology, nutrition and eating disorders. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

TETON'S SPORTS MEDICINE CONFERENCE — July 7-11, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: Conference Center, Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 16 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Current concepts on evaluation, conditioning, management and rehabilitation of the recreational and competitive athlete as well as use of exercise therapy in a variety of medical problems and injuries. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

UNIVERSITY OF KANSAS

COMMUNICATING WITH CHILDREN (HEARING AND SPEECH) — April 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians and Speech/Language/Hearing Clinicians.

35TH ANNUAL SYMPOSIUM ON ANESTHESIOLOGY — April 19-21, 1985. Sponsor: University of Kansas Medical Center. Location: Westin Crown Center Hotel, One Pershing Road, Kansas City, Missouri. Credit: 15.5 hrs. AMA Cat. I, 14 hrs. AAFP, 14 hrs. AANA. Fee: $225 Physicians, $150 Nurse Anesthetists.

11TH ANNUAL FAMILY PRACTICE SYMPOSIUM — April 24-25, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of

Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for physicians.

29TH ANNUAL SYMPOSIUM ON INFECTIOUS DISEASE — April 26, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

ANNUAL PATHOLOGY SYMPOSIUM — April 27, 1985. Sponsor: University of Kansas Medical Center. Location: Rieke Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: TBA. Credit: Hours TBA for Physicians.

SAM E. ROBERTS NUTRITION PROGRAM: MINERALS IN HUMAN NUTRITION — CLINICAL APPLICATION — April 30, 1985. Sponsor: Academy of Health Professions and University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $100 Physicians, $40 Nurses, Dietitians, Allied Health Professionals, no charge to students and residents. Credit: 7 contact hours each for physicians, nurses, dietitians, physical therapists, and respiratory therapists. Contact: Ida Tilden, Academy of Health Professions, 2920 McGee Trafficway, Kansas City, MO 64108, (816) 531-4559.

WHAT'S NEW IN DIABETES? — May 1, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: AMA 7.5 hrs. Cat. I, AAFP 7.5 hrs., CNE 8 hrs., Dietitian 8 hrs., SW 8 hrs.

DIABETES FOR PHYSICIANS — May 2, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Missouri. Credit: AMA 4 hrs., AAFP 4 hrs. Fees: $10 (includes lunch).

ADVANCED CARDIAC LIFE SUPPORT — March 20-21, 1985, May 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Building, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $150 physicians, $75 nurses, EMTs. Credit: 13.5 hrs. AMA Cat. I, 13.5 hrs. AAFP, American Heart Association Certification.

TECHNOLOGICAL ADVANCES IN RESPIRATORY CARE — May 9-10, 1985. Sponsor: University of Kansas Medical Center. Location: Hilton Plaza Inn, 45th and Main, Kansas City, Missouri. Credit: 11 hrs. AMA, AAFP, CNE, RT, CRNA.

KANSAS MEDICINE: TEN YEARS LATER — May 17, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 6 hrs AMA, AAFP.

ADVANCED CARDIAC LIFE SUPPORT — May 21-22, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Bldg., University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA, 13.5 hrs. AAFP. Fees: $150 physicians, $75 nurses, EMTs.

THE CHILD WITH CHRONIC DISEASE — May 23-24, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA, AAFP, CNE.

ADVANCED TRAUMA LIFE SUPPORT — May 30-31, 1985. Sponsor: University of Kansas Medical Center. Location: Orr-Major Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 16 hrs. AMA, 15 hrs. AAFP, 15 hrs. AOA. Fees: $375. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-6124.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — June 13-14, 1985. University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA. Fees: $625.

SCHEDULED MEETINGS

ALASKA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION — June 5-8, 1985 in Haines, Alaska. Registration should be sent in care of: Alaska State Medical Association, 4107 Laurel Street, Suite 1, Anchorage, Alaska 99508, (907) 562-2662.

Welcome New Members

Vonn E. Roberts, M.D.
4009 Avenue B, #11
Scottsbluff, NE 69361

Raymond A. Zukaitis, M.D. (Reinstated)
76th & Main, #213
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Bruce Smith, M.D.
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Robert K. Dellinger, M.D.
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David M. Cathro, M.D. (Reinstated)
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Syed Mohiuddin, M.D. (Reinstated)
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Cheri Jensen, M.D.
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In Memoriam

By medicine life may be prolong'd
yet death
Will seize the doctor too.
—Shakespeare

Edward Ford, M.D. — (Born 1929 - died January 12, 1985) — Medical Specialty — Family Practice. Doctor Ford was a graduate of the Creighton University School of Medicine in 1963. He was a member of the Nebraska Medical Association. Survivors include his wife, Doctor Linda Ford, Bellevue, daughters, Cinda Lou Sherman and Wendolyn Cottrell, both of Bellevue; sons, John of Gainsville, Florida, and William of Bellevue; mother, Zola Ford of Independence, Missouri, and seven grandchildren.

Randolph H. Tibbels, M.D. — (Born August 23, 1908 - died January 12, 1985) — Medical Specialty — Family Practice. Doctor Tibbels was a graduate of the University of Nebraska College of Medicine in 1932. He was a member of the American Medical Association and the Nebraska Medical Association. Doctor Tibbels is survived by his wife, Ethel; four children, Doctor Tom Tibbels of West Point, Mike Tibbels of Norfolk, Mrs. Gordon (Nancy) Englert of Billings, Montana, and Doctor Terry Tibbels of Carlsbad, California; 16 grandchildren; three sisters and one brother.

Dorwin B. Wengert, M.D. — (Born 1904,died February 9, 1985) — Medical Specialty — General Practice. Doctor Wengert was a graduate of the University of Nebraska College of Medicine in 1929. He was a member of the American Medical Association and the Nebraska Medical Association.

WashingtoNotes

NIH Panel Mixes Surgery for Sarcomas

Following the trends towards less destructive cancer therapies, a panel of physicians convened by the National Institutes of Health has recommended that radiation and chemotherapy can replace amputation as the best treatment of sarcomas.

Multiple studies from major medical centers indicate that amputation can be avoided without jeopardizing the lives of these patients, the experts said at an NIH conference.

Amputation has been the traditional mainstay of treatment of adult soft-tissue and oeteogenic sarcomas because of high recurrence rates when only local surgical resections were performed. Yet removal of the limb impairs a patient's function and erodes his self-confidence, the NIH panel said.

During the past 15-20 years, radiation and chemotherapy have become increasingly effective in treating the 4,800 cases of soft-tissue sarcoma and 1,900 cases of osteosarcomas diagnosed each year. Between 30 and 50 cancer centers around the country now are exploring these alternatives to amputation. Amputation and limb-sparing treatments show similar rates of local recurrence of cancer: 0-10% in cases of soft-tissue sarcoma and 10-20% in osteosarcoma. Five year survival rates for the two different treatments also are similar.

For soft tissue sarcoma, the experts recommend:

* use of shrinking fields to limit the highest dose of radiation to the area at greatest risk for tumor persistance,
* saving a 1 cm longitudinal strip of normal tissue along the limb to prevent edema, and
* delivery of doses of 5,500 to 6,500 cGy over 5½ to 7 weeks.

For osteosarcoma, they suggest:

* use of either intra-arterial or intravenous chemotherapy.
* adjuvant treatment to reduce local recurrance, and
* possible use of pre-operative regional chemotherapy to product necrosis in tumors.

There are situations, they point out, when limb-sparing treatment is not appropriate. For example, such treatment should not be used for lesions with little surgical margin or for lesions that involve major vessels and nerves. Limb function, if salvagable, should be at least equal to that of a prosthetic device. For instance, legs should be able to bear weight and hands should be functional.

* * *

1984 Sees PRO Startups

Over the objections of a leery White House budget office, physicians in 1984 managed to hang on to a pivotal Medicare review role intended to protect the program's coffers as well as its patients.

Government negotiators drove a hard bargain, however, and the new Peer Review Organizations (PROs) that will be performing the reviews have made some formidable commitments that are likely to bring about — or at least hasten — major changes in the way medicine is practiced in the U.S. Few of the winning contractors have any illusions about their future should they fail to live up to their bargains.

The brainchild of Minnesota Republican Senator David Durenberger, the PROs were established in a 1982 law as a replacement of the predecessor Professional Standards Review Organization program. Federal efforts to get the new PROs up and running didn't start in earnest until February 1984 when bid requests for the two-year PRO contracts were finally issued, however.

The PROs will differ from the old PSROs in several important ways. Their workload has been consolidated so that where there were about 200 PSRO areas, there are only 54 PRO areas. Although PSROs were not precluded from reviewing private patients care, the PROs not only are permitted but are required to conduct private reviews when requested. And perhaps most important, the PROs will be working under performance-based contracts that spell out some very specific goals they are to achieve.

The goals, aimed at curbing potential abuses under Medicare's prospective price controls, include several intended to reduce hospital admissions. The PROs also are directed to assure that quality of care does not deteriorate. In fact, federal officials increased their demands in the quality area after complaints that initial bidding guidelines were deficient in this area.

The bulk of the PRO contract awards (44) went to the old PSROs; a number of other new PROs have PSRO subcontractors. Nine state medical societies (Maryland, Indiana, Missouri, Nebraska, New York, North Carolina, Texas, and Virginia) also won PRO bids. In seven areas, review will be conducted by another state's PRO. Only in Idaho will the review be performed by one of the insurers that administer Medicare for the government.

The bidding outcome was a relief to many observers who thought more of the contracts would go to Medicare intermediaries.

Typically, the first round of PRO review will be done by nurses and other non-MDs. No claim may be denied for payment without approval of a physician, however, so physicians will be deeply involved in PRO reviews. In most PRO areas, at least 20% of physicians have indicated support for the PRO and many will be working as consultants or reviewers.

As a result, PROs' effect on physicians' practices is likely to greatly exceed that of the old PSROs. While some practitioners may not feel the impact until the first claims and denials start spewing out of the system in about six months, others will be affected immediately. Some M.D.s, for instance, have already received the unwelcome news that either they or the hospitals where they practice have been singled out for special attention from the PRO. Nineteen of the new organizations have identified specific physicians who hospitalizations will be extensively monitored.

If PROs do all the things they say they will, 595,000 surgeries will be shifted out of hospitals and into ambulatory setting; more than 425,000 admissions in specific hospitals elilinated; and 290,000 unnecessary or inappropriate admissions or procedures elimnated.

Medicare/Medicaid Cuts Foreseen in Budget

As the Reagan Administration continues to develop and revise its 1986 budget proposal, Congressional reaction seems to indicate that lawmakers may tinker with the proposed Medicare and Medicaid cuts. If the cuts become part of a general freeze on all federal programs, however, modifications are much less likely. Among the areas where Congress would change the President's proposal are Medicare freezes on payment levels to physicians and hospitals, reductions in federal Medicaid funds, and increases in cost-sharing for Medicare beneficiaries.

Although the President has acknowledged that his budget proposal will include a one year extension of the current freeze on physician fee levels, details of the plan have not been made available. There are strong signals that the proposal will apply to all physicians, including those who signed "participating physician" agreements last fall.

One incentive for signing the participating agreement — which commits the MD to accepting the Medicare fee level as full payment for all cases — was the promise of a potentially higher fee allowance at the conclusion of the current freeze on October 1, 1985.

Congressional staffers report that some lawmakers are therefore reluctant to freeze fees of participating physicians because they see this as reneging on a financial commitment they made to these MDs. Other members are said to believe freezing fees of the participating physician would in effect terminate an experiment they want to continue.

The President also has announced that he wants to freeze Medicare payment rates for hospitals. Under current law, hospital rates would be permitted to increase by a percentage equal to the increase in the market basket of goods and services they purchase plus 0.25%. Under the budget proposal, no increase would be permitted.

Hospitals are concerned that the proposed freeze could mean that some institutions, rather than receiving the same payment per case in 1986 as in 1985, would actually receive lower payments.

Industry officials who argue that many of these may be institutions that have higher costs because they provide more indigent care, treat sicker patients or are located in high cost areas are calling for protection for some of these facilities.

Several alternatives have emerged. One would simply provide that no hospital would receive a lower payment per case in 1986 than in 1985, this "holding (the hospitals) harmless." Another would freeze the current 50-50 split between the hospital specific and the national portions of the DRG rate. A third proposal, backed by the American Hospital Association, would blend the national and hospital specific rate separately for each DRG based on how much costs for the particular DRG varied among hospitals.

Hospital spokesmen say they believe there is support for both a "hold harmless" proposal and a phase-in freeze. In addition, a preliminary study from the Congressional Budget Office, while not endorsing the AHA-proposed blending approach, has concluded that blending would be accomplished without any increase in DRG rates and that it would narrow the range of gains and losses that hospitals would experience under a fully-national DRG rate.

Lawmakers are also worried about cuts that could harm beneficiaries. Health and Human Services Secretary Margaret Heckler has suggested that an Office of Management and Budget proposal to raise the Medicare Part B premium to cover 35% of the program costs by 1990 be modified to cover only 30% of costs. Two influential Senate Republicans, Majority Leader Robert Dole of Kansas and Senate Finance health subcommittee chairman David Durenberger, reportedly are ready to offer the Heckler proposal as an alternative. Democrats can be expected to press for the reduction or elimination of increased beneficiary cost-sharing.

Even more controversy has arisen over the President's call for a $1 billion reduction in federal Medicaid expenditures in fiscal 1986 and a cap that in following years would permit increases only equal to the rise in the gross national product deflator. The administration is now said to have modified the plan by creating a $300 million fund to help states that were unable to curb Medicaid costs despite 'good faith efforts".

* * *

Heckler Calls for Tobacco Tax Extension

Amidst continued speculation over the fiscal 1986 Reagan Administration budget, HHS Secretary Margaret Heckler has proposed extending the current 16 cent federal excise tax on cigarettes to help stave off bankruptcy in the Medicare hospital trust fund.

The tobacco tax, which was raised from 8 cents to 16 cents on January 1, 1983, was scheduled to return to 8 cents on October 1, 1985. Heckler's proposal would continue the current rate after expiration date. The revenues gained from not reducing the tax would be earmarked for the hospital trust fund. The Congressional Budget Office and the Treasury Department had previously estimated that this would increase federal revenues by $7.6 billion from 1986 through 1989.

The proposal also is similar to legislation that has been introduced by California Democrat Rep. Fortney Stark.

* * *

Medicare Offers HMO Option

A new prospective payment option for Medicare HMO enrollees, scheduled to take effect February 1, is expected to encourage up to 800,000 Medicare beneficiaries to join HMOs or other competitive medical plans within the next three or four years.

Final regulations to implement the new payment method were published in the Federal Register on January 10. The reimbursement change, which results from a 1982 law, would institute a program that American Medical Association delegates have urged be delayed.

Substantial changes have been made in the rules since they were first proposed last May. The most significant is a requirement that Peer Review Organizations review the care of Medicare HMO enrollees.

The new rules give HMOs, preferred provider organizations and other alternative delivery plans two payment options. The plan may either continue under the cost-based arrangements nearly all HMOs operate under today. Or it may be paid a prospective monthly fee for each of its Medicare beneficiaries.

Under the prospective payment, HMOs would receive up to 95% of Medicare's average cost per beneficiary in the community for each Medicare HMO enrollee. Adjustments would be made for age, sex and institutional status of the Medicare enrollees.

The HMOs or other prospectively-paid plans must provide benefits at least equal to those of Medicare. If the plan's cost of providing care to Medicare recipients is less than 95% of Medicare's so-called average adjusted per capita cost, the HMO must accept a lower payment or provide more benefits to Medicare enrollees. Plans may charge a premium to cover the costs of extra services and premiums are expected to range from $20 to $50.

Beneficiaries would still be liable for the monthly Part B premium and could also still be held responsible for cost-sharing equal to the current liability in the standard Medicare plan. Based on the experience of HMOs participating in a demonstration of a similar Medicare financing arrangement, many of the plans are expected to reduce or eliminate current cost-sharing, however.

Twenty-one HMOs have participated in the demonstration but an evaluation of the demonstration has not been completed. The demonstration did show that large numbers of Medicare beneficiaries will enroll in HMOs when offered new benefits not covered by Medicare.

It has also raised some concerns, however, particularly in Florida, where the General Accounting Office is investigating one demonstration plan—the International Medicare Centers. Other concerns about the new payment method have centered primarily on costs, potential withholding of needed services, and administrative feasibility of calculating the average adjusted per capita cost.

* * *

Medicare "Participation" at 30%; Accepted Claims Rise

About 30% of physicians treating Medicare patients signed "participating agreements" with the program in fiscal 1984. At the same time, the number of claims for which physicians accepted Medicare fee allowances as full payment rose to a record 66.5% in November of last year.

The physician sign-up rates varied by state and by specialty, ranging from 5.6% in South Dakota to 53.9% in Alabama and from 18.2% for some miscellaneous surgical specialties to 50.8% for nephrologists.

The "participating" concept was established in legislation enacted last fall and now under challenge in federal courts by the American Medical Association, the Indiana Medical Society and some individual physicians. The law froze Medicare fees for all physicians until October 1985 and provided financial and administrative incentives for practitioners who agreed to "participate". Participating physicians must accept assignment on all Medical claims, billing the patient only for the 20% of the Medicare allowable fee that is not paid by the program.

In fiscal 1984, about 56% of Medicare claims were taken on assignment and about 20% of physicians reportedly always assigned claims, according to HCFA. In fiscal 1985, some 118,428 physicians, or 29.8% of those treating Medicare patients, signed participating agreements. Assignment rates, which had been rising slowly since 1976, jumped to 66.5% of all claims, or 5% higher than their previous high of 61.5% in 1969, HCFA says.

In addition to physicians, some 19,751 or 34% of non-physician practitioners treating Medicare patients and 17,822 or 23.8% of Medicare suppliers signed agreements.

In three states and the District of Columbia, more than half of all physicians with Medicare patients signed participating agreements, HCFA reported. Following Alabama were Kansas and the District at 52.9% and Pennsylvania at 51.1%. Other states where more than 40% of physicians agreed to participate are New Mexico (48.6%), Massachusetts (47.9%), Rhode Island (46%), Arkansas (44.6%), Michigan (43.4%) and Vermont (42.2%).

In South Dakota, only 5.6% of physicians agreed to participate and in Alaska 9.4% signed agreements. Other states with participating rates of less than 15% are North Dakota (10.4%), Idaho (11%), Oklahoma (12.8%), South Carolina (13.5%), and Oregon (13.8%).

Among physician specialty groups, the highest sign-up rates occurred among nephrologists, who typically treat large percentages of Medicare patients under the program's End Stage Renal Disease Treatment coverage.

The hospital-based specialties of radiology (41.3%) and pathology (39.6%) also showed higher than average sign-up rates while anesthesiologists were at 21.1%.

* * *

Peer Review Suit Filed by Hospital Association

Making good on a long-standing threat, the American Hospital Association has sued the federal government over its implementation of Medicare peer review organizations (PROs).

One issue in the suite—the issuance of four sets of final PRO regulations—may be close to resolution, however, with reports that the regulations have cleared a snag in the Office of Health and Human Services Secretary Margaret Heckler and been sent to the Office of Management and Budget.

The regulations govern the way PROs conduct review, the appeals and sanctions processes, and the confidentiality of PRO data. Both hospitals and PROs have complained about the lack of final regulations. Minnesota Republican Senator David Durenberger has said that one of his first items of business as chairman of the Senate health subcommittee will be hearings on the program.

PRO supporters hope the AHA legal action and the promised hearings will forestall implementation of the program.

Another snarl in the overall implementation of the program has arisen, however, with the decision by PRO officials to reopen bidding on a so-called Super PRO contract. Four bids reportedly were received on the contract but the only organization which has publically acknowledged its bid is the American Medical Association.

AHA's decision to sue the government came six months after the organization, representing 7000 hospitals, first charged that the numerical objectives in PRO contracts amounted to "quotas" to reduce Medicare hospital admissions by 1.25 million in two years.

An earlier threat to sue was dissipated by repeated assurances from HCFA officials that the contract objectives wuld be renegotiated if they proved unreasonable. In recent months, AHA officials had said they were "cautiously optimistic" that their problems with the PRO program could be worked out. Association spokesman said the decision to proceed with the suit resulted from"membership pressure". HHS Secretary Margaret Heckler cancelled a scheduled appearance at an annual AHA meeting after learning of the suit.

Filed January 29 in the U.S. District Court in the District of Columbia, the lawsuit does not seek to stop the operation of the PRO program. Instead it complains of inadequate public accountability in the installation of the program and calls on HHS to follow the Administrative Procedures Act in implementing the review system. HHS will have 60 days to answer the AHA complaint.

* * *

NIH Research Grants in Jeopardy

For many medical investigators gearing up for their newest research project, federal cutbacks have suddenly hit home in January.

After receiving letters from the National Institutes of Health (NIH) last year indicating they could expect funding in January, some 1500 researchers received a second letter saying that their grant proposals are being reevaluated, and may be rejected.

The trouble revolves around the Reagan Administration's interpretation of law.

Last year Congress passed a bill that funded certain levels of NIH research, stating that the money would go toward 6600 grants. The Administration, while leaving the total amount of money intact, now says that it will be spent on only 5000 grants and rather than devoting the money to one-year grants, as Congress intended, the Administration says the money will go toward the second and third-year funding of some grants as well. Administration officials say that these changes in NIH spending patterns will save at least $280 million a year in upcoming years.

Researchers most likely to be hurt are those on the borderline of funding. NIH observers say that the cutoff "priority score"—which ranks a project based on its potential contribution to science — will shift.

The cutbacks will affect all types of medical research, including studies of cancer, heart disease, arthritis, immunology, cell biology, molecular genetics, neurological disorders, and stroke. Specific cut-off levels will vary from institution to institution, NIH officials note.

Congressional response has been muted as legislators wait to see the specific features of the upcoming 1986 budget. This budget will reveal how many additional cuts can be expected by NIH — and will influence how hard Congress will decide to fight.

* * *

Oral Dosage Drug For Herpes Cleared

The Food and Drug Administration in January cleared a pill to treat genital herpes.

The oral dosage form of acylovir will be marketed under the name Zovirax. It will join the intravenous and ointment forms of the drug in attempting to capture the $220 million herpes market. The product is manufactured by Burroughs Wellcome Co. and could aid the 5 million to 20 million Americans believed to be affected by the disease.

* * *

New Cesarean Guidelines Issued

The American College of Obstetricians and Gynecologists (ACOG) has issued new guidelines that encourage women who have had a previous cesarean birth to deliver their next child vaginally.

As many as 280,000 of the 700,000 cesarean births performed each year are indicated because of a previous cesarean delivery. Of these women, roughly 100,000 could instead have a safe vaginal birth, ACOG said.

ACOG's new guidelines, could slow the steady rise in the number and rates of cesarean births. Of all cesarean births, 55% are due to a previous cesarean, 24% are due to "failure to progress" in labor, 13% are due to fetal distress, and 5% are due to breech presentation of the infant.

* * *

Aspirin/Reyes Warning Set

Aspirin manufacturers this month agreed to develop new labels that warn of a possible link between aspirin and Reyes syndrome.

Their action was based on newly released data from Centers for Disease Control study which reveals a strong association between the children's disease and the use of aspirin.

Researchers found that 97% of children with Reye's Syndrome were reported to have used aspirin during respiratory or chicken pox illnesses before the onset of Reye's Syndrome. Of control case groups without Reyes Syndrome, between 28% and 55% had received aspirin for matching illnesses.

In response to HHS Secretary Margaret Heckler's request, aspirin manufacturers voluntarily agreed to:

* place a warning on aspirin packages.
* discontinue any promotion for use of their produce in cases of flu or chicken pox.
* warn that physicians be notified before use of aspirin in cases of flu or chicken pox.

The reduced incidence of the disease over the past several years — from 454 cases in 1975 to 190 cases in 1984 — has been attributed to the decline in the use of aspirin among young children.

* * *

Vaccine Woes Heard On Capitol Hill

Unless government stockpiles are substantially bolstered and manufacturers are relieved of some liability, other vaccines could suffer the same fate as the diptheria, tetanus, and pertussis (DTP) vaccine, Congress was warned this month.

Two lots of the DTP vaccine recently failed to meet potency standards, creating a sudden shortage of 2 million doses of the vaccine. The shortage forced physicians across the country to postpone booster shots to any child more than a year old.

Levels of oral polio vaccine (OPV) have also taken an unexpected dive. Last summer, when Lederle Labs removed aging doses of OPV from government stockpiles to distribute to physicians, backup supplies dropped from 3.4

million doses to 600,000 doses. If production had been suddenly interrupted, the nation would have had less than 12 days supply of the polio vaccine.

The situation has not created a health crisis at this time. Most children are already immunized against the diseases and partial immunizations are not expected to reduce immunity. But Congress and the medical community believe the government should protect itself from fires, explosions, potency problems, and other sudden interruptions in vaccine production.

"At best, we are in a situation with an uncertain vaccine supply. At worst, there could be dangerous shortages, postponements of immunizations, and outbreaks of disease," said Alan R. Nelson, MD, Board member of the AMA, at a January hearing before a House subcommittee.

The stockpiling program falls far short of national needs, charged Rep. Henry Waxman (D-CA) and other members of Congress. Because the Reagan Administration has failed to provide adequate funding, vaccine stockpile levels stay dangerously low, they said.

The problem could be eased by making the vaccine business more attractive to manufacturers by reducing the number of lawsuits, witnesses said. The present dollar demand of DTP lawsuits against Lederle is 200 times greater than their total sales of the vaccine in 1983.

Within the medical and congressional communities, there is general agreement that Congress should take steps to compensate children and families injured by vaccines. A federally sponsored compensation program, financed by a general revenue trust fund or a surcharge on each dose of vaccine, could also reduce the number of lawsuits, proponents believe.

* * *

Anti-Abortion Bills Sent to Congress

The first of a series of anti-abortion bills was introduced in the Senate's opening days in January.

The bill, called the "Unborn Children's Civil Rights Act of 1985" (S. 46), was introduced by Sen. Jesse Helms (R-NC) and Gordon Humphrey (R-NH) and endorsed by a coalition of anti-abortion groups.

The proposed legislation states that:

* scientific evidence demonstrates that abortion takes the life of an unborn child who is a human being,

* the right to an abortion is not secured by the Constitution, and

* the Supreme Court, in its Roe v. Wade decision, erred in not recognizing the humanity of the unborn child.

It also denies federal funding for abortion and fetal research, except to save the lives of the mother or child.

* * *

Organ Task Force Formed

The new Task Force on Organ Transplantation, established by the Department of Health and Human Services this month, will begin reviewing the nation's organ transplant network in February.

The task force, authorized by the National Organ Transplantation Act of 1984, will advise HHS on the medical, lethal, ethical, economic, and social aspects of organ transplantation. It also will advise HHS on the feasibility of setting up grant programs to develop new procurement organizations and networks.

It must report to HHS and Congress on issues of immunosuppressive drugs by July and prepare a final report by next January.

* * *

Doctor Draft Revisited

The Pentagon should draft doctors and other health care professionals for rapid induction in the event of a war, according to a Heritage Foundation report released in January.

The U.S. Armed Services are short 60,000 medical specialists and could only treat a small fraction of the battlefield wounded if large-scale conventional warfare breaks out, said the author of the report, former director of the Army Reserve Maj. Gen. Henry Mohr (USA-Ret).

The report recommended immediate registration of all persons between the ages of 18 and 46 who are trained in health care occupations. Both women and men should be drafted, he said, as well as all persons with technical medical skills.

Yielding to heavy opposition from the American Medical Association, American Nurses Association, the American Public Health Association and other groups, the Pentagon recently abandoned a peacetime registration plan for drafting doctors and other health care workers.

A draft discriminates against physicians and other health care professionals because it would subject them to a special military registration and to potential induction throughout their lives, AMA said. Increased efforts to recruit physicians — by offering attractive benefits, for instance — would boost health care manpower, the AMA believes.

Under current Pentagon plans, a physician draft will be part of a broad "Mobilization Day" registration plan, to be handed over to Congress only in the event of "World War III or another national emergency," said a Pentagon spokesman.

* * *

Oral Anti-Herpes Drug Approved

The FDA has approved the oral form of the anti-herpes virus drug Acyclovir (Burroughs-Wellcome). The agency will continue to require surveillance of the use of the drug when it is on the market. It wants to monitor the effects of the drug and the possibility that the herpes virus might develop resistance to acyclovir. Although it is recommended only for the treatment of genital herpes, not oral herpes, the availability of acyclovir in the oral form (it is already on the market in an injectable form) will widen the use of the drug considerably. Studies have shown there is an 85% reduction in recurrences of genital herpes infections when they are adequately treated with the oral form.

* * *

Professional Liabilty High on States' Agendas

Nineteen states expect to consider medical malpractice legislation in 1985 and seven states see this as one of the top three health issues they will face this year, according to a new survey by the National Conference of State Legislatures.

The survey ranked care of the medically indigent as the top issue in the states in 1985 and it found several other issues — including long term care and Medicaid reimbursement of physicians and hospitals — that outscored malpractice in terms of the number of states that saw it as a major issue.

Nevertheless, an NSCL official said he believes that medical malpractice "will be on the platter in every state" in the country.

All told, the states anticipate deliberations on about 39 malpractice bills. Thirteen legislatures are likely to consider general limits on malpractice awards and a bill introduced in Colorado would limit malpractice recoveries whenever a second opinion had been obtained. Thirteen states will consider placing ceilings on lawyers fees while 12 may require arbitration of medical malpractice suits. Colorado, Delaware, Florida, Kansas, Michigan, Utah, and Wisconsin ranked malpractice as one of the top three issues the legislatures would face in 1985.

The NSCL survey, which was conducted in November and December of 1984, found that states will consider more than 585 health care cost containment bills in 1985. Forty states responded to the survey.

State Medicaid programs and physician services to these patients also will absorb a great deal of the legislators' attention. Thirteen states identified Medicaid hospital and physician care as top priorities in 1985. Eleven states are expected to consider requiring or encouraging Medicaid recipients to get all their care from a primary care MD. Six (Alabama, California, Colorado, Indiana, Minnesota, and Oregon) are likely to debate proposals that would require Medicaid patients to go only to physicians under contract to the state. Six states will probably consider contracting with hospitals for services to Medicaid patients. Eight may require prior authorization for all hospital care.

* * *

PROGRAM

117TH ANNUAL SESSION

NEBRASKA MEDICAL ASSOCIATION

IN CONJUNCTION WITH:

Nebraska Allergy Society
Nebraska Society of Anesthesiologists
American Cancer Society
Missouri Valley Dermatologic Society
Nebraska Chapter, American College of Emergency Physicians
Nebraska Chapter, American Academy of Family Physicians
American Heart Association, Nebraska Affiliate, Lincoln Division
Nebraska Section, American College of Obstetricians & Gynecologists
Nebraska Academy of Ophthalmology
Nebraska Academy of Otolaryngology
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Nebraska Perinatal Organization
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Nebraska Psychiatric Society
Nebraska Radiological Society
Nebraska Chapter, American College of Surgeons
Nebraska Thoracic Society

APRIL 26 - 29, 1985
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NOTE: Annual Session registrants are welcome at all scientific programs. Only business meetings are limited to specialty group members.

117TH ANNUAL SESSION NEBRASKA MEDICAL ASSOCIATION

PURPOSE:

To advance the science and art of medicine and to elevate the standards of medical education. Meetings of the Annual Session are devoted to the scientific work of the members, disseminating to members and others, facts and opinions relating to medical knowledge, treatment and procedures.

The Scientific Sessions Committee of the Nebraska Medical Association, as its continuing medical education mission, seeks to satisfy the educational needs and interest of participants in the Nebraska Medical Association with scientifically sponsored programs. Needs and interest are adjusted according to geographic and physician specialty requests on an annual review basis.

The overall goal of this scientific program is to substantiate or change the attitude and approach of the physician to the solution of a given medical problem, present new knowledge in a specific area, update data and introduce new specific skills and techniques.

SPONSORSHIP:

The meeting is sponsored by the Scientific Sessions Committee of the Nebraska Medical Association in conjunction with the Nebraska Allergy Society, the Nebraska Society of Anesthesiologists, the American Cancer Society, the Missouri Valley Dermatologic Society, the Nebraska Chapter, American College of Emergency Physicians, the Nebraska Chapter, American Academy of Family Physicians, the American Heart Association, Nebraska Affiliate, Lincoln Division, the Nebraska Section of the American College of Obstetricians and Gynecologists, the Nebraska Academy of Ophthalmology, the Nebraska Academy of Otolaryngology, the Nebraska Chapter of the American Academy of Pediatrics, the Nebraska Perinatal Organization, the Nebraska Society of Plastic and Reconstructive Surgeons, the Nebraska Psychiatric Society. the Nebraska Radiological Society, the Nebraska Chapter of the American College of Surgeons, and the Nebraska Thoracic Society.

CREDIT:

This program has been reviewed and is acceptable for 22¾ Prescribed hours by the American Academy of Family Physicians.

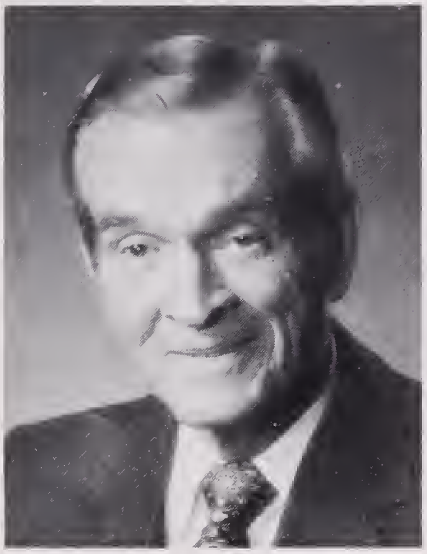
As an organization accredited for continuing medical education, the Scientific Sessions Committee of the NMA certifies that this continuing medical education offering meets the criteria for 22 ¾ hours of credit in Category I, provided the program is used and completed as designed.

GENERAL INFORMATION

The host facility for the Annual Session is the Cornhusker Hotel, 333 South 13th Street, Lincoln, NE 68508 (402) 474-7474.

REGISTRATION: The registration desk will be located in the Cornhusker Square Atrium. Registration begins at 7:00 a.m., Friday, April 26. Identification badges must be worn by all persons attending the session.

HERBERT E. REESE, M.D.
President 1984-85



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* * *

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II.	Howard A. Dinsdale, M.D., Lincoln	1987
III.	C. T. Frerichs, M.D., Beatrice	1987
IV.	Roger Massie, M.D., Plainview	1987
V.	William J. Chleborad, M.D., Fremont	1985
VI.	Robert W. Herpolsheimer, M.D., Seward	1985
VII.	Robert Quick, M.D, Crete	1985
VIII.	Thomas H. Wallace, M.D., Gordon	1985
IX.	Warren G. Bosley, M.D., Grand Island	1986
X.	George Lytton, M.D., Hastings	1986
XI.	R. E. Donaldson, M.D., North Platte	1986
XII.	R.G. Heasty, M.D., Scottsbluff	1986

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Stanley M. Truhlsen, M.D., Omaha	1985

* * *

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* * *

Delegates to AMA

John D. Coe, M.D., Omaha	1986
C. J. Cornelius, Jr., M.D., Sidney	1985

Alternate Delegates to AMA

Blaine Y. Roffman, M.D., Omaha	1986
Louis J. Gogela, M.D., Lincoln	1985

* * *

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ACKNOWLEDGEMENTS

The Nebraska Medical Association gratefully acknowledges the support of the following organizations for their contribution to the 1985 Annual Session.

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Physicians' Professional Liability * Professional Office Package * PAK II® * Personal & Commercial Umbrellas

SANDOZ PHARMACEUTICALS
Mellaril * Parlodel * Visken * Restoril

NEBRASKA MEDICAL ASSOCIATION BUSINESS SESSIONS

Board of Directors
Friday, April 26, 7:00 a.m., Room F
Saturday, April 27, 8:00 a.m., Meeting Room 3

Board of Councilors
Friday, April 26, 10:00 a.m., Meeting Room 1

House of Delegates
First Session:
  Friday, April 26, 1:30 p.m., Rooms D, E, & F

RECOGNITION OF FIFTY-YEAR PRACTITIONERS

Paul M. Bancroft, M.D., Lincoln
John G. Brazer, M.D., Omaha
Julius B. Christensen, M.D., Omaha
Carl J. Formanack, M.D., Syracuse
Clarence Mel Hartmann, M.D., Omaha
Wayne M. Hull, M.D., St. Petersburg, FL
Frank J. Iwerson, M.D., Omaha
James F. Kennedy, M.D., Alliance
William Riley Kovar, M.D., Omaha
Wilbur A. Muehlig, M.D., Omaha
John A. Rosenau, M.D., Scottsbluff
Maurice M. Steinberg, M.D., Omaha
Robert S. Wigton, M.D., Omaha

Reference Committees, 2:30 p.m.

Second Session:
  Sunday, April 28, 9:30 a.m., Rooms D, E, & F
    Presentation of AMA Education and Research Foundation Checks
    Presentation of Nebraska Medical Foundation Student Research Scholarship Checks

Third Session:
  Sunday, April 28, 4:00 p.m., Rooms D, E, & F

Nominating Committee
First Session:
  Friday, April 26, 4:00 p.m., Meeting Room 2

Second Session:
  Saturday, April 27, 9:00 a.m., Meeting Room 2

Honors Luncheon
Past Presidents' and 50-Year Practitioner Luncheon
Friday, April 26, 11:30 a.m., Room C

PROGRAM

MONDAY, APRIL 29

Sportsman's Day

10:30 a.m. SPORTSMAN'S DAY LUNCH
The Country Club of Lincoln
3200 South 24th Street
(Participation by preregistration only)
Donald E. Waltemath, M.D., Chairman
J. G. Wiedman, M.D., Vice Chairman

12:00 noon GOLF TOURNAMENT
The Country Club of Lincoln
3200 South 24th Street
(Shotgun Tee Off)
(Participation by preregistration only)
Donald E. Waltemath, M.D., Chairman
J. G. Wiedman, M.D., Vice Chairman

12:30 p.m. TENNIS TOURNAMENT
Lincoln Racquet Club
5300 Old Cheney Road
(Participation by preregistration only)
Tom Kos, M.D., Chairman

1:00 p.m. FIRST ANNUAL BIKE RIDE
Leave from Lincoln Racquet Club
5300 Old Cheney Road
Participants must bring their own bicyles
William T. Griffin, M.D., Chairman

2:00 p.m. NMA 10K RUN
Recreation Center, Lincoln Air Park West,
4000 NW 46th
(Participation by preregistration only)
Irving E. Weston, M.D., Chairman
Richard Jackson, M.D., Vice Chairman

5:00 p.m. SPORTSMAN'S DAY SOCIAL HOUR
The Country Club of Lincoln
3200 South 24th Street
Donald E. Waltemath, M.D., Chairman
J. G. Wiedman, M.D., Vice Chairman

6:00 p.m. SPORTSMAN'S ANNUAL AWARD DINNER
The Country Club of Lincoln
3200 South 24th Street
(Participation by preregistration only)
Donald E. Waltemath, M.D., Chairman
J. G. Wiedman, M.D., Vice Chairman

SPECIALTY SOCIETY BUSINESS SESSIONS

Nebraska Allergy Society
Saturday, April 27, 7:30 a.m., Room B

Nebraska Section, American College of Obstetricians & Gynecologists
Saturday, April 27, 10:00 a.m., Meeting Room 7

Nebraska Academy of Ophthalmology
Saturday, April 27, 4:00 p.m., Room E

Nebraska Chapter, American Academy of Pediatrics
Saturday, April 27, 4:15 p.m., Room C

Nebraska Perinatal Organization
Friday, April 26, 4:30 p.m., Rooms A & B

Nebraska Society of Plastic & Reconstructive Surgeons
Saturday, April 27, 10:00 a.m., Room 418

Nebraska Radiological Society
Saturday, April 27, 2:00 p.m., Nebraska Club, 20th Floor
First National Bank Building

Nebraska Chapter, American College of Surgeons
Saturday, April 27, 5:00 p.m., Room D

NOTES

PROGRAM

FRIDAY, APRIL 26

7:15 a.m. to 6:00 p.m. **Perinatal Workshop**
Rooms A & B
Sponsored by —
Nebraska Perinatal Organization
Program Chairman & Moderator —
Lawrence C. Bausch, M.D., Lincoln

Fifth Annual Nebraska Perinatal Workshop

7:15 **Registration**

8:00 **Welcome** — Lawrence C. Bausch, M.D., Lincoln

8:05 **Truth Disclosure — Communicating Bad News to Parents**
Peter Rosenbaum, M.D., Hamilton, Ontario, Canada

9:00 **Neonatal Seizures**
George J. Wolcott, M.D., Lincoln

9:55 **Break**

10:15 **The Frustrated Perinatal Nurse**
Lois Sonstegard, R.N., Ph.D., Buffalo, Minnesota

11:10 **Hocus Pocus: Antibiotics and Premature Labor**
Paul R. Meier, M.D., Marshfield, Wisconsin

12:00 **Lunch** — Center Hall
Environmental Agents Which Cause Handicap Conditions in Children
James W. Hanson, M.D., Iowa City, Iowa

Workshops
(Choice of One)

1:30 **Session A**
Budgeting Your Way To Be Heard Better
Lois Sonstegard, R.N., Ph.D., Buffalo, Minnesota
Session B
Cesarean Birth: Cure-All or Cop-Out
Paul R. Meier, M.D., Marshfield, Wisconsin

2:45 **Break**

Workshops
(Choice of One)

3:15 **Session A**
Home Phototherapy
Robert M. Nelson, Jr., M.D., Omaha
Session B
Stillborns in Nebraska
Bruce A. Buehler, M.D., Omaha
Kenton L. Shaffer, M.D., Kearney

The Fifth Annual Nebraska Perinatal Workshop Program has been designed to update health care professionals in regard to mother and newborn.

4:30 **Business Meeting of the Nebraska Perinatal Organization**
Robert M. Nelson, Jr., M.D., Omaha, Chairman

4:45 **Wine & Cheese Party** — Center Hall
(Perinatal Workshop Registrants Only)
Compliments of Ross Laboratories

PROGRAM

FRIDAY, APRIL 26

9:00 a.m. to 5:00 p.m. **Cardiology**
Meeting Room 9
Sponsored by —
American Heart Association, Nebraska Affiliate, Lincoln Division in cooperation with the **Nebraska Chapter, American Academy of Family Physicians**

Program Chairman —
Jeffery A. Grubbe, M.D., Lincoln

An Update on the Diagnosis and Treatment of Arrhythmias

9:00 **Welcome**
Paul W. Jewett, M.D., Lincoln
Richard A. Blatny, M.D., Fairbury

Moderators —
Jeffery A. Grubbe, M.D., Lincoln
Richard A. Blatny, M.D., Fairbury

9:05 **Arrhythmias Seen in Ischemic Ventricles**
William Nelson, M.D., Tampa, Florida

9:50 **Management of Arrhythmias: Pharmacologic Agents**
Lofty L. Basta, M.D., Tulsa, Oklahoma

10:35 **Break**

10:45 **Workshops — Session I**

Meeting Room 7
Diagnosis — Common Arrhythmias
Alan D. Forker, M.D., Lincoln

Meeting Room 8
Diagnosis — Complex Arrhythmias
Toby R. Engel, M.D., Omaha

Meeting Room 9
Cost-Effective Work-Ups of Arrhythmias
LeeRoy E. Meyer, M.D., Omaha

Room 418
Pacemaker Associated Arrhythmias
Walt Weaver, M.D., Lincoln

Room 518
Drug Interactions
Alan S. Marion, M.D., Ph.D., Lincoln

Room 618
Pediatric and Adolescent Arrhythmias
John D. Kugler, M.D., Omaha

PROGRAM

FRIDAY, APRIL 26

12:00 **Lunch** — Meeting Rooms 2, 3, & 4

1:00 **Cardiac Arrhythmias — When Not to Treat**
William Nelson, M.D., Tampa, Florida

1:45 **Cardiac Pacers — When, Which, Why**
Lofty L. Basta, M.D., Tulsa, Oklahoma

2:30 **Break**

2:45 **Workshops — Session II**

Meeting Room 3
Diagnosis — Common Arrhythmias
Alan D. Forker, M.D., Lincoln

Meeting Room 4
Diagnosis — Complex Arrhythmias
Toby R. Engel, M.D., Omaha

Meeting Room 7
Cost-Effective Work-Ups of Arrhythmias
LeeRoy E. Meyer, M.D., Omaha

Meeting Room 8
Pacemaker Associated Arrhythmias
Walt Weaver, M.D., Lincoln

Meeting Room 9
Drug Interactions
Alan S. Marion, M.D., Ph.D., Lincoln

Room 418
Pediatric and Adolescent Arrhythmias
John D. Kugler, M.D., Omaha

4:00 **Panel Discussion — Questions From Registrants**

5:00 **Adjournment**

This course is designed to review both cardiac and pacemaker arrhythmias with emphasis on diagnosis and treatment. In addition, cost effective evaluation of dysrhythmias as well as pacemaker indications will be presented. And discussion on pharmacologic agents as well as drug interactions will be discussed as well. This course is aimed at both primary care and subspecialty physicians who deal with cardiac patients.

PROGRAM

FRIDAY AFTERNOON, APRIL 26

2:00 p.m. **Cancer Society**
to Meeting Room 1
5:00 p.m. Sponsored by —
American Cancer Society
Program Chairman —
George E. Larson, M.D., Lincoln

Early Diagnosis and Follow-Up of Colo-Rectal Cancer
Moderator — John B. Davis, M.D., Omaha

2:00 **Colo-Rectal Health "Check" Program**
George E. Larson, M.D., Lincoln

2:20 **Flexible Fiberoptic Sigmoidoscopy**
David R. Dyke, M.D., Lincoln

2:40 **Methodist Hospital, Omaha, Experience With Mass Hemoccult Screening**
Timothy B. Denzler, M.D., Omaha

3:00 **Hemaquant Detection of Colo-Rectal Neoplasia**
John G. Wiedman, M.D., Lincoln

3:20 **The Malignant Polyp Problem**
Jerald R. Schenken, M.D., Omaha

3:40 **Follow-Up for Colo-Rectal Cancer and Polyp Patients**
Mark A. Christensen, M.D., Omaha

4:00 **Colo-Rectal Cancer Families in Nebraska**
Henry T. Lynch, M.D., Omaha

This course will present the most common cancer in the State of Nebraska, colo-rectal cancer. The objective of this course is to emphasize early detection and treatment of colo-rectal cancer, an effort which can return three out of four patients to normal active lives.

2:00 p.m. **Emergency Medicine**
to Room C
5:00 p.m. Sponsored by —
Nebraska Chapter, American College of Emergency Physicians
Program Chairman & Moderator —
Richard L. Keller, M.D., Omaha

Toxicology — Poisonings

2:00 **"Occult" Poisonings — Case Studies**
Richard L. Keller, M.D., Omaha

2:30 **General Management of the Poisoning Victim**

2:45 **Activated Charcoal — Single and Multiple Dose Uses**

3:05 **Organophosphates — SLUD**

3:20 **Polycyclic Overdose**

3:45 **Potpourri of Poisonings**

4:05 **Acetaminophen & Aspirin**

4:35 **Question Session**
Panel

This course is designed to give the clinician a better understanding of poisoning - both the obvious and the not so obvious with emphasis on management and caveats of care.

PROGRAM

FRIDAY EVENING, APRIL 26

5:30 p.m. **Socio-Economic**
to Rooms D, E, & F
9:00 p.m. Sponsored by —
Nebraska Medical Association
Program Chairman & Moderator
Michael Breiner, M.D., Lincoln

5:30 **Reception & Dinner**

The Medical Practice Industry . . . Medicine in Transition

7:00 **The Revolution in Physician Economics and Management**
Thomas E. Zirkle, Boulder, Colorado
President, Zirkle, Lee and Associates, Ltd.

7:45 **Questions & Answers**

8:00 **The Entrepreneurial Physician of the '80's**
Thomas E. Zirkle, Boulder, Colorado

8:45 **Questions & Answers**

Thomas E. Zirkle

*Appreciation is expressed to the Olney Foundation, Inc. for its contribution.

PROGRAM

SATURDAY MORNING, APRIL 27

7:30 a.m. to 10:00 a.m. **Allergy**
Room B
Sponsored by —
Nebraska Allergy Society
Program Chairman & Moderator —
Frederic Kiechel, III, M.D., Lincoln

7:30 **Nebraska Allergy Society Breakfast Business Meeting**

8:00 **Current Controversies in the Treatment of Asthma**
Miles M. Weinberger, M.D., Iowa City, Iowa

The objective of this course is to review current controversies regarding the treatment of asthma. This will include the use of theophylline and metaproteranol.

*Appreciation is expressed to William H. Rorer, Inc. for their contribution.

10:00 a.m. to 1:00 p.m. **Thoracic Medicine**
Room B
Sponsored by —
Nebraska Thoracic Society
Program Chairman & Moderator —
Thomas C. Tinstman, M.D., Omaha

Esophageal Reflux & Aspiration Pneumonia

10:00 **In Children**
Jon A. Vanderhoof, M.D., Omaha
John L. Colombo, M.D., Omaha

10:45 **In The Adult**
Edwin C. Schafer, M.D., Omaha
Thomas C. Tinstman, M.D., Omaha

11:30 **Panel Discussion on Treatment by the Participants**

12:00 **Luncheon** — Room F
Current Research Topics
Stephen I. Rennard, M.D., Omaha

The course is designed to discuss the current methods of diagnosis for esophageal reflux, prevention of aspiration and treatment of esophageal reflux and aspiration pneumonia.

PROGRAM

SATURDAY, APRIL 27

9:00 a.m. to 5:00 p.m. **Pediatrics**
Room C
Sponsored by —
Nebraska Chapter, American Academy of Pediatrics
Program Chairman — H. J. Kuehn, M.D., Omaha
Moderator — Harlan C. Shriner, M.D., Lincoln

9:00 **UNMC Resident Paper**

9:15 **Creighton Resident Paper**

9:30 **UNMC Resident Paper**

9:45 **Creighton Resident Paper**

10:00 **Questions/Answers**

10:15 **Break**

10:30 — The following portion of the meeting is presented by the Missouri Valley Dermatologic Society
Moderator — Elliott L. Rustad, M.D., Lincoln
Panel Discussion: Pediatric Dermatology
Christopher P. Crotty, M.D., Omaha
Stephen C. Papenfuss, M.D., Omaha
Margaret Sutton, M.D., Lincoln

12:00 **Luncheon for Nebraska Chapter Members** —Meeting Room 4
Moderator — Warren G. Bosley, M.D., Grand Island

1:15 **The Pediatrician's Role in School Health**
Jerome Newton, M.D., San Antonio, Texas

2:15 **Sports Physical: Pro's & Con's**
Warren G. Bosley, M.D., Grand Island

2:45 **Panel Discussion**

3:30 **Alternate Health Plan Update**
Mr. Ralph Morocco, Jr., Omaha

4:00 **Break**

4:15 **Nebraska Chapter, American Academy of Pediatrics Business Meeting**
Presiding — Dale W. Ebers, M.D., Chapter Chairman, Lincoln

The objective of this course is to update the primary care physician in areas of adolescent medicine.

PROGRAM

SATURDAY MORNING, APRIL 27

9:00 a.m. to 12:00 noon Dermatology

Room E

Sponsored by —
Missouri Valley Dermatologic Society

Program Chairman —
Rodney S. W. Basler, M.D., Lincoln

Moderator — Richard Q. Crotty, M.D., Omaha

9:00 **Panel Discussion: Dermatology in General Clinical Practice**
Rodney S. W. Basler, M.D., Lincoln
John R. Luckasen, M.D., Omaha
Herschel E. Stoller, M.D., Omaha

10:30 — The following portion of the program is presented as a segment of the Nebraska Chapter, American Academy of Pediatrics Meeting Room C

Moderator — Elliot L. Rustad, M.D., Lincoln

Panel Discussion: Pediatric Dermatology
Christopher P. Crotty, M.D., Omaha
Stephen C. Papenfuss, M.D., Omaha
Margaret Sutton, M.D., Lincoln

This course is divided into two sections, the first presenting common dermatologic conditions seen in general clinical practice. The second section will deal with specific skin problems seen in a pediatric patient population focusing on eczema, congenital lesions, and acne, including the use of Accutane.

10:00 a.m. to 12:00 noon Plastic & Reconstructive Surgery

Room 418

Sponsored by —
Nebraska Society of Plastic & Reconstructive Surgeons

Program Chairman —
John J. Heieck, M.D., Omaha

10:00 **Business Meeting**
Presiding — John J. Heieck, M.D., President, Omaha

PROGRAM

SATURDAY, APRIL 27

10:00 a.m. to 3:00 p.m. Radiology

Nebraska Club, 20th Floor
First National Bank Building

Sponsored by —
Nebraska Radiological Society

Program Chairman & Moderator
Susan M. Williams, M.D., Omaha

10:00 **Nebraska Radiological Society Executive Committee Meeting**

11:00 **The Midline Sagittal Section in Neonatal Intracranial Ultrasound**
William L. Harrison, M.D., Omaha

11:20 **Ultrasound Evaluation of the Cervix**
Ronald D. Irsik, M.D., Omaha

11:35 **A New Look at Pulmonary Infarction**
Jud W. Gurney, M.D., Omaha

12:00 **TMJ Arthrography**
Phoebe A. Kaplan, M.D., Omaha

12:30 **Cocktails & Luncheon**

2:00 **Business Meeting**

This course is designed to present topics of current interest to practicing radiologists.

10:00 a.m. to 1:00 p.m. Obstetrics & Gynecology

Meeting Room 7

Sponsored by —
Nebraska Section, American College of Obstetricians & Gynecologists

10:00 **Annual Business Meeting**
Presiding — Larry E. Roffman, M.D., Section Chairman, Omaha

11:30 **Break**

12:00 **Luncheon** — Meeting Room 1

DAILY SCHEDULE

FRIDAY, APRIL 26

GENERAL REGISTRATION: 7:00 a.m., Cornhusker Square Atrium

Cancer Society

Scientific Program, 2:00 p.m. - 5:00 p.m., Meeting Room 1

Cardiology

Scientific Program, 9:00 a.m. - 5:00 p.m., Meeting Room 9
Luncheon, 12:00 noon, Meeting Rooms 2, 3, & 4

Emergency Medicine

Scientific Program, 2:00 p.m. - 5:00 p.m, Room C

Honors Luncheon

50-Year Practitioner and NMA Past Presidents Luncheon, 11:30 a.m., Room C

NMA Business Sessions

Board of Directors, 7:00 a.m., Room F
Board of Councilors, 10:00 a.m., Meeting Room 1
House of Delegates, 1:30 p.m. - 3:00 p.m., Rooms D, E, & F
Nominating Commitee, 4:00 p.m., Meeting Room 2

Perinatal Workshop

Scientific Program, 8:00 a.m. - 4:30 p.m., Rooms A & B
Luncheon, 12:00 noon, Center Hall
Business Meeting, Nebraska Perinatal Organization, 4:30 p.m., Rooms A & B
Nebraska Perinatal Organization Wine & Cheese Party, 4:45 p.m., Center Hall

Socio-Economic

Reception and Dinner, 5:30 p.m. - 7:00 p.m., Rooms D, E, & F
Program, 7:00 p.m. - 9:00 p.m., Rooms D, E, & F

SATURDAY, APRIL 27

GENERAL REGISTRATION: 7:00 a.m., Cornhusker Square Atrium

Allergy

Business Meeting, Nebraska Allergy Society, 7:30 a.m., Room B
Scientific Program, 8:00 a.m. - 10:00 a.m., Room B

Anesthesiology

Scientific Program, 12:00 noon - 5:00 p.m., Meeting Room 9

Dermatology

Scientific Program, 9:00 a.m. - 12:00 noon, Room E

NMA Business Sessions

Board of Directors, 8:00 a.m., Meeting Room 3
Nominating Committee, 9:00 a.m., Meeting Room 2

Obstetrics & Gynecology

Business Meeting, Nebraska Section, American College of Obstetricians & Gynecologists, 10:00 a.m. - 11:30 a.m., Meeting Room 7
Luncheon, Nebraska Section, American College of Obstetricians & Gynecologists, 12:00 noon, Meeting Room #1

Ophthalmology

Luncheon, National Society to Prevent Blindness, Nebraska Affiliate, 12:00 noon, Room E
Scientific Program, 2:00 p.m. - 4:00 p.m., Room E
Business Meeting, Nebraska Academy of Ophthalmology, 4:00 p.m. Room E

Otolaryngology

Scientific Program, 10:00 a.m. - 12:00 noon, Meeting Room 8
Luncheon, Nebraska Academy of Otolaryngology, 12:00 noon, Meeting Room 5

Pediatrics

Scientific Program, 9:00 a.m. - 4:00 p.m., Room C
Luncheon for Chapter Members, Nebraska Chapter, American Academy of Pediatrics, 12:00 noon, Meeting Room 4
Business Meeting, Nebraska Chapter, American Academy of Pediatrics, 4:15 p.m., Room C

Plastic & Reconstructive Surgery

Business Meeting, Nebraska Society of Plastic & Reconstructive Surgeons, 10:00 a.m. - 12:00 noon, Room 418

Psychiatry

Scientific Program, 1:00 p.m. - 4:00 p.m., Room B

Radiology

Executive Committee Meeting, Nebraska Radiological Society, 10:00 a.m. - 11:00 a.m., Nebraska Club, 20th Floor, First National Bank Building
Scientific Program, 11:00 a.m. - 12:30 p.m., Nebraska Club
Luncheon, Nebraska Radiological Society, 12:30 p.m. - 2:00 p.m., Nebraska Club
Business Meeting, Nebraska Radiological Society, 2:00 p.m. - 3:00 p.m., Nebraska Club

Surgery

Scientific Program, 10:00 a.m. - 5:00 p.m., Room D
Luncheon, Nebraska Chapter, American College of Surgeons, 12:00 noon, Meeting Rooms 2 & 3
Business Meeting, Nebraska Chapter, American College of Surgeons, 5:00 p.m., Room D

Thoracic Medicine

Scientific Meeting, 10:00 a.m. - 12:00 noon, Room B
Luncheon, 12:00 noon, Room F

Alumni Meeting

University of Nebraska College of Medicine Alumni Meeting and Social Hour, 4:30 p.m., Room F

SATURDAY EVENING

Fun Night, 7:00 p.m., Rooms A, B, & C, Cocktails 6:00 p.m., Center Hall

SUNDAY, APRIL 28

GENERAL REGISTRATION: 7:00 a.m., Cornhusker Square Atrium

General Session

Medicare/Medicaid Program, 8:00 a.m. - 9:30 a.m., Rooms B & C

NMA Business Sessions

House of Delegates, 9:30 a.m - 11:30 a.m., Rooms D, E, & F, 4:00 p.m. - 5:00 p.m., Rooms D, E, & F
Medicine & Religion Luncheon, 11:30 a.m. - Rooms B & C

Sunday Evening

Presidents' Reception for Physicians and their Spouses, 6:00 p.m., Rooms A, B, & C
Inaugural Banquet for Physicians and their Spouses, 7:00 p.m., Rooms D, E, & F

MONDAY, APRIL 29

Sportsman's Day

Sportsman's Day Lunch, 10:30 a.m., Lincoln Country Club, 3200 South 24th Street
Golf Tournament, 12:00 noon, Lincoln Country Club, 3200 South 24th Street
Tennis Tournament, 12:30 p.m., Lincoln Racquet Club, 5300 Old Cheney Road
First Annual Bike Ride, 1:00 p.m., leave from Lincoln Racquet Club, 5300 Old Cheney Road
NMA 10K Run, 2:00 p.m., Recreation Center, Lincoln Air Park West, 4000 NW 46th
Sportsman's Day Social Hour, 5:00 p.m., Lincoln Country Club, 3200 South 24th Street
Sportsman's Annual Award Dinner, 6:00 p.m., Lincoln Country Club, 3200 South 24th Street

PROGRAM

SATURDAY, APRIL 27

10:00 a.m. to 6:00 p.m. **Surgery**
Room D
Sponsored by —
Nebraska Chapter, American College of Surgeons
Program Chairman —
Scott G. Rose, M.D., F.A.C.S., Omaha
Moderator —
Jon S. Thompson, M.D., F.A.C.S., Omaha

10:00 **Cervical Spine Injury: Incidence and Diagnosis**
Betty L. Bryson, M.D., Omaha
Bill L. Mumford, R.N., B.S., Omaha
Mark Mulkey, Medical Student, Omaha
Michelle Schwedhelm, R.N., Omaha
Kathryn Warren, R.N., B.S.N., Omaha

10:15 **Hepatic Artery Infusion Chemotherapy - A Report on It's Effectiveness**
Michael P. Durr, M.D., Omaha
Robert J. Fitzgibbons, Jr., M.D., F.A.C.S., Omaha
James A. Mailliard, M.D., Omaha

10:30 **Comparison of Operative and Percutaneous Catheter Drainage of Intra-Abdominal Abscesses**
Stephen P. Moessner, M.D., Omaha
Jon S. Thompson, M.D., Omaha
Robert P. Lieberman, M.D., Ralston

10:45 **Enteral Hyperalimentation with Catheter Jejunostomy in Thoracic Surgery**
Aviel Roy-Shapira, M.D., Omaha
Tom R. DeMeester, M.D., Omaha

11:00 **Experience with Pancreaticoduodenectomy at University Hospital**
Patrick R. Greer, M.D., Omaha
Jon S. Thompson, M.D., Omaha
Paul E. Hodgson, M.D., Omaha

11:15 **Adenocarcinoma Arising in Barrett's Esophagus**
John B. Davis, M.D., Omaha
Marcie Hannigan Peterson, M2, Omaha

11:30 **Carcinoid Tumors: Twenty Year Statewide Veteran's Administration Hospital Experience and a Review of the Literature**
Martin L. Rothberg, M.D., Omaha
Michael P. Durr, M.D., Omaha
Denitsu Hirai, M.D., F.A.C.S., Omaha

11:45 **Chordoid Sarcoma: Report of an Unusual Case and Discussion of Surgical Treatment**
Martin L. Rothberg, M.D., Omaha
Robert J. Fitzgibbons, Jr., M.D., F.A.C.S., Omaha
David A. Katz, M.D., Omaha

12:00 **Luncheon** — Meeting Rooms 2 & 3
Moderator — Betty Bryson, M.D. F.A.C.S., Omaha

1:00 **Familial Carotid Body Tumors: Report of Experience with a Kindred of Six**
Garnet J. Davis, M.D., Omaha
James A. Edney, M.D., Omaha
Todd J. Freeman, Omaha

1:15 **The Time Interval with Metachronous Colon Cancer**
Patrick J. Kiefer, M.D., Omaha
Alan G. Thorson, M.D., Mn.
Mark A. Christensen, M.D., Omaha

1:30 **Characteristics of Breast Cancer in Women Over 80 Years of Age**
Steven J. Davis, M.D., Omaha
F. William Karrer, M.D., Omaha
Scott G. Rose, M.D., Omaha
Greg Eakins, M3, Omaha

1:45 **Peritoneovenous Shunting for Malignant Ascites**
Steven C. Poplawski, M.D., Omaha
James A. Edney, M.D., Omaha
Margaret A. Tempero, M.D., Omaha

2:00 **Comparison of Colectomy for Benign and Malignant Diseases**
Garnet J. Davis, M.D., Omaha
Jon S. Thompson, M.D., Omaha

2:15 **Increased Incidence of Pancreas Related Complications with Postoperative Pancreatitis**
Larry E. Bragg, M.D., Omaha
Jon S. Thompson, M.D., Omaha
David A. Burnett, M.D., Omaha
Paul E. Hodgson, M.D., Omaha
Layton F. Rikkers, M.D., Omaha

2:30 **Use of the Internal Oblique Muscle in Reconstructive Surgery**
John J. Edney, M.D., Omaha
John J. Heieck, M.D., Omaha
Carl H. Dahl, M.D., Omaha
M. Edward Baccari, M.D., Omaha

2:45 **Break**

3:00 **Immediate Post-Mastectomy Breast Reconstruction**
Michael P. Durr, M.D., Omaha
John J. Heieck, M.D., F.A.C.S., Omaha
Carl H. Dahl, M.D., F.A.C.S., Omaha
M. Edward Baccari, M.D., F.A.C.S., Omaha
John J. Edney, M.D., Omaha

3:15 **Management of Impotence with the Inflatable Penile Prosthesis**
Ansar U. Khan, M.D., F.A.C.S., Fremont
Louis W. Gilbert, M.D., Fremont

3:30 **Hypospadia New Prospects**
Arnaldo Trabucco, M.D., Omaha
Francis F. Bartone, M.D., F.A.C.S., F.A.A.P., Omaha

3:45 **Use of Intestinal Segments in Urology**
Carl J. Cascione, M.D., Omaha
M. Belayet Hussain, M.B.B.S., Omaha
Francis F. Bartone, M.D., Omaha
Stephen A. Holt, D.O., Omaha

4:00 **Thoracic Aorta-Femoral Artery Bypass Graft: Long-Term Results**
Dwaine J. Peetz, Jr., M.D., Omaha
A. V. Sterpetti, M.D., Omaha
Richard J. Feldhaus, M.D., Omaha

4:15 **Management of Abdominal Aortic Aneurysm in the Aged**
A. V. Sterpetti, M.D., Omaha
Richard D. Schultz, M.D., Omaha
Richard J. Feldhaus, M.D., Omaha
Dwaine J. Peetz, Jr., M.D., Omaha
J. M. McGill, M.D., Omaha

4:30 **Eversion Endarterectomy of Superficial Femoral Artery and End-to-Side Anastomosis of "Distal" Profunda: An Alternative to Extended Profundoplasty**
Richard J. Feldhaus, M.D., Omaha
A. V. Sterpetti, M.D., Omaha
Richard D. Schultz, M.D., Omaha
Dwaine J. Peetz, Jr., M.D., Omaha
A. J. Fasciano, B.S., Omaha

4:45 **Short-Term Results in Patients Requiring Myocardial Revascularization After Percutaneous Transluminal Coronary Angioplasty (PTCA)**
Patrick J. Kiefer, M.D., Omaha
Lynne Duren Barkmeier, M.D., Omaha
Richard D. Schultz, M.D., Omaha
Richard J. Feldhaus, M.D., Omaha
Dwaine J. Peetz, Jr., M.D., Omaha

5:00 **Business Meeting**

PROGRAM

SATURDAY MORNING, APRIL 27

10:00 a.m. to 1:00 p.m. **Otolaryngology**
Meeting Room 8
Sponsored by —
Nebraska Academy of Otolaryngology
Program Chairman and Moderator —
Frederic Ogren, M.D., Omaha

Management of Cancer in the Neck

10:00 **Management of Subclinical Cancer in the Neck**
Daniel J. Remmler, M.D., Sacramento, Calif.

11:00 **The Role of Neck Dissection in the Management of Cervical Metastatic Disease**
Daniel J. Remmler, M.D., Sacramento, Calif.

12:00 **Luncheon** — Meeting Room 5

This course will cover the management of metastatic squamous cell carcinoma of the neck, including the N_O neck. Different modalities of cervical lymph node dissection will be discussed, including the indications and techniques of the functional neck dissection.

PROGRAM

SATURDAY AFTERNOON, APRIL 27

12:00 noon to 5:00 p.m. **Anesthesiology**
Meeting Room 9
Sponsored by —
Nebraska Society of Anesthesiologists
Program Chairman & Moderator —
Charles Gregorius, M.D., Lincoln

Clinical and Legal Update for the Anesthesiologist

12:00 **Anesthesia for Uncomplicated Obstetrics**
Gerard M. Bassell, M.D., Wichita, Kansas

12:50 **Anesthesia for Complicated Obstetrics**
Gerard M. Bassell, M.D., Wichita, Kansas

1:45 **Minimizing Your Malpractice Exposure**
Mr. William M. Lamson, Jr., Omaha

2:45 **Anesthesia and the Trauma Patient**
David N. Skurdal, M.D., Baltimore, Maryland

3:35 **Anesthesia and the Trauma Patient (continued)**
David N. Skurdal, M.D., Baltimore, Maryland

4:30 **Panel: Questions & Answers**
Gerard M. Bassell, M.D., Wichita, Kansas
Mr. William Lamson, Jr., Omaha
David N. Skurdal, M.D., Baltimore, Maryland

This program will present a clinical update on two diverse clinical subjects, anesthesia for trauma and obstetrics. A presentation on professional liability will provide a non-clinical balance and should be of interest to all.

PROGRAM

SATURDAY AFTERNOON, APRIL 27

12:00 noon to 5:00 p.m. **Ophthalmology**
Room E
Sponsored by —
Nebraska Academy of Ophthalmology
Program Chairman & Moderator —
Everett Madson, M.D., Omaha

12:00 **Luncheon**
Held in conjunction with the National Society to Prevent Blindness, Nebraska Affiliate

Surprise! New Views From An Old Society
Randall Dotson, M.D., Lincoln
Midge Irvin, Lincoln
Bobbie Allen, Lincoln

2:00 **General Session**

Use of Prisms in Strabismus
William E. Scott, M.D., Iowa City, Iowa

3:00 **Treatment of Esotropia**
William E. Scott, M.D., Iowa City, Iowa

4:00 **Business Meeting**
Presiding — Jan V. Jensen, M.D., President, Kearney

These presentations will cover the medical treatment of strabismus.

1:00 p.m. to 4:00 p.m. **Psychiatry**
Room B
Sponsored by —
Nebraska Psychiatric Society
Program Chairman —
Lillian R. M. Stoller, M.D., Omaha

1:00 **The Geriatric Patient: Effective Management of Behavioral & Mental Disorders — A Compendium of Key Issues for the Primary Care Physician**
—A 2-hour video tape program moderated by Steven Gambert, M.D., Valhalla, New York
Discussion Panel:
Jay A. Rich, M.D., Omaha
Jehangir B. Bastani, M.D., Lincoln
William C. Bruns, M.D., Omaha

PROGRAM

SATURDAY, APRIL 27

4:30 p.m. **University of Nebraska College of Medicine Alumni Meeting & Social Hour**
Room F

6:00 p.m. **1985 Annual Session Fun Night**
Program Chairman —
Michael Breiner, M.D., Lincoln

6:00 **Cocktails** — Center Hall

7:00 **Dinner** — Rooms A, B, & C
4077th T.R.A.S.H. presents:
Is There a Doctor in the House?
—Superb entertainment by physicians' wives from Rapid City, South Dakota

4077th T.R.A.S.H.

*Appreciation is expressed to Intermedics, Inc. and to For-Med, Inc. for their contribution to Fun Night.

PROGRAM

SUNDAY, APRIL 28

8:00 a.m. to 9:30 a.m. **General Session**
Rooms B & C
Sponsored by —
Nebraska Medical Association

Presiding — Herbert E. Reese, M.D., Lincoln

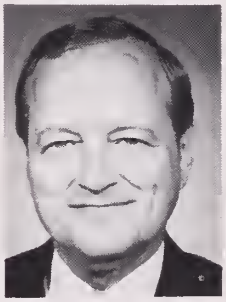
Breakfast with Dunning & Bradley

Medicare/Medicaid . . . Changes in Delivery and Reimbursement

Gina C. Dunning, Lincoln
Director, Dept. of Social Services
State of Nebraska

Wayne W. Bradley, Washington, D.C.
Vice President, Public Affairs
American Medical Association

Gina C. Dunning



Wayne W. Bradley

11:30 a.m. **Medicine & Religion Luncheon —**
For Physicians and their Spouses
Rooms B & C
Presiding — Herbert E. Reese, M.D., Lincoln

Relationships Between Law, Ethics, & Medicine
Ann M. Rhodes, R.N., M.A., J.D., Iowa City, Iowa
Assistant to the Director
The University of Iowa Hospitals and Clinics

PROGRAM

Francis D. Donahue, M.D.
Omaha

Joseph F. Boyle, M.D.
Los Angeles, California

PROGRAM

SUNDAY, APRIL 28

6:00 p.m. **Presidents' Reception —**
For Physicians and their Spouses
Rooms A, B, & C
Honoring the President of the Nebraska Medical Association and the President of the Nebraska Medical Association Auxiliary

7:00 p.m. **Inaugural Banquet —**
All physicians and spouses are cordially invited to attend the inauguration of Francis D. Donahue, M.D.
Rooms D, E, & F
Presiding — Paul E. Collicott, M.D.
President, Lancaster County Medical Society

Installation of Francis D. Donahue, M.D.

If We Don't Care, Who Does?
Joseph F. Boyle, M.D.
Los Angeles, California
President, American Medical Association

GUEST FACULTY

Nebraska Allergy Society
Miles M. Weinberger, M.D.
Chairman, Pediatric Allergy & Pulmonary Division
University of Iowa School of Medicine
Iowa City, Iowa

Nebraska Society of Anesthesiologists
Gerard M. Bassell, M.D.
Staff Anesthesiologist
Wesley Medical Center
Wichita, Kansas

David N. Skurdal, M.D.
Staff Anesthesiologist
Maryland Institute for Emergency Medical Services
Baltimore, Maryland

American Heart Association, Nebraska Affiliate, Lincoln Division in cooperation with the Nebraska Chapter, American Academy of Family Physicians
Lofty L. Basta, M.D.
Director of Education and Research
St. John's Cardiovascular Institute
Tulsa, Oklahoma

William Nelson, M.D.
Professor of Medicine
University of South Florida College of Medicine
Tampa, Florida

Nebraska Academy of Ophthalmology
William E. Scott, M.D.
Professor of Ophthalmology
Dept. of Ophthalmology
University of Iowa Hospitals & Clinics
Iowa City, Iowa

Nebraska Academy of Otolaryngology
Daniel J. Remmler, M.D.
Dept. of Otolaryngology
Kaiser Permanente Medical Center
Sacramento, California

Nebraska Chapter, American Academy of Pediatrics
Jerome Newton, M.D.
Director of School Health Services
San Antonio Independent School District
San Antonio, Texas

Nebraska Perinatal Organization
James W. Hanson, M.D.
Professor of Pediatrics
Chairman, Division of Medical Genetics
University of Iowa
Iowa City, Iowa

Paul R. Meier, M.D.
Staff Perinatologist
Marshfield Clinic
Marshfield, Wisconsin

Peter Rosenbaum, M.D.
Director of Pediatrics
Chedoke Child and Family Care Centre
Chedoke-McMaster Hospitals
Hamilton, Ontario, Canada

Lois Sonstegard, R.N., Ph.D.
Private Consulting in Parent-Child Nursing & Hospital Finance
Buffalo, Minnesota

Nebraska Psychiatric Society
Steve Gambert, M.D.
Professor of Medicine
Chief, Division of Gerontology & Geriatric Medicine
Dept. of Medicine
Director, Center on Aging & Human Development
New York Medical College
Valhalla, New York

60th Annual Meeting of the Nebraska Medical Association Auxiliary

If your physician spouse is eligible to be a Nebraska Medical Association member, you are eligible to be a member of the Auxiliary. Please join us for any or all of the scheduled activities.

WE WELCOME YOU!

Auxiliary PROGRAM

MRS. DUANE KRAUSE
Fremont, Nebraska
President 1984-85

MRS. LESLIE GRACE
Blair, Nebraska
President 1985-86

MRS. WAYNE C. BRADY
President, American Medical Association Auxiliary, Inc.
Greenville, South Carolina

60th Annual Meeting of the Nebraska Medical Association Auxiliary

A CORDIAL INVITATION IS EXTENDED TO EACH AUXILIARY MEMBER IN NEBRASKA. WE URGE YOU TO REGISTER AND ATTEND ALL OF OUR ACTIVITIES. WELCOME TO LINCOLN!

Registration: Cornhusker Square Atrium
Friday, April 26, 1985 — 8:30 a.m. to 2:00 p.m. and 4:00 p.m. to 6:00 p.m.
Saturday, April 27, 1985 — 8:30 a.m. to 9:30 a.m.

Convention Committee Chairmen — 1985

General Chairman:
Mrs. Craig Urbauer (Joyce)
General Co-Chairman:
Mrs. Glen Lau (Elba)
Registration:
Mrs. Sushil Lacy (Jane)
Reservations:
Mrs. John Reed (Kay)
Progressive Dinner:
Mrs. L. Palmer Johnson (Shirley)
Mrs. Michael Breiner (Kay)
Brunch:
Mrs. Harold Cahoy (Joan)
Mrs. Randall Dotson (Joni)
Publicity:
Mrs. Charles Barton (Anne)
Courtesy:
Mrs. Robert Osborne (Desta)
Correspondence:
Mrs. Harry Shaffer (Dorothy)
Transportation:
Mrs. Donald Waltemath (Judy)

Auxiliary PROGRAM

FRIDAY, APRIL 26

8:30 a.m. **Registration** — Cornhusker Square Atrium
8:30 a.m. to 2:00 p.m. and
4:00 p.m. to 6:00 p.m.

9:45 a.m. **Annual Board Meeting** — Meeting Rooms 5 & 6
All Members Welcome
Mrs. Duane Krause (Helen), NMA Auxiliary President, Presiding

12:00 noon **Luncheon** — All Members Welcome
Meeting Rooms 5 & 6

1:00 p.m. **Seminar** — Meeting Rooms 5 & 6
Calling the Shots, The Advertising of Alcohol
Becky Beardsley, Lincoln Council on Alcohol and Drugs

6:30 p.m. **Progressive Dinner**
Appetizers — Home of Mrs. George Gammel
7220 Lincolnshire Rd.
Entree & Dessert — Home of Mrs. L. Palmer Johnson, 7075 Lincolnshire Rd.
—Desserts demonstrated by Mrs. Noble Swanson
—Proceeds to the Health Galleries

Please sign at Registration Desk if transportation is needed. Meet in the Cornhusker Lobby at 6:00 p.m. for transportation. Maps are available at the Registration Desk.

SATURDAY, APRIL 27

8:30 a.m. **Registration** — Cornhusker Square Atrium
8:30 a.m. to 9:30 a.m.

10:00 a.m. **Awards Brunch** — The Country Club of Lincoln
3200 South 24th Street

Special Guest
Mrs. Wayne C. Brady (Billie), President
American Medical Association Auxiliary
Greenville, South Carolina

Presentation of Awards

Installation of Officers

Entertainment — Excerpts from "Greater Tuna" — Bob Hinrichs and Steve Lewis

Please sign at Registration Desk if transportation is needed. Meet in the Cornhusker Lobby at 9:30 a.m. for transportation. Maps are available at the Registration Desk.

Gavel Club Meeting — immediately following brunch

2:00 p.m. **Christlieb Art Tour** — Love Library

6:00 p.m. **Fun Night for Physicians and Spouses Reception**
Cornhusker Center Hall

7:00 p.m. **Dinner & Entertainment**
Rooms A, B, & C

4077th T.R.A.S.H. presents:
Is There a Doctor in the House?

—Superb entertainment by physicians' wives from Rapid City, South Dakota

Auxiliary PROGRAM

SUNDAY, APRIL 28

9:30 a.m. **House of Delegates, Nebraska Medical Association**
Rooms D, E, & F
Presentation of AMA Education and Research Foundation Checks
Presentation of Nebraska Medical Foundation Student Research Scholarship Program Checks

11:30 a.m. **Medicine & Religion Luncheon —**
Rooms B & C

Relationships Between Law, Ethics & Medicine
Ann Rhodes, R.N., M.A., J.D., Iowa City, Iowa

1:00 p.m. **Post-Convention Board Meeting**
Meeting Room 1
All Members Welcome
Mrs. Leslie Grace (Ardis)
1985-86 NMA Auxiliary President, Presiding

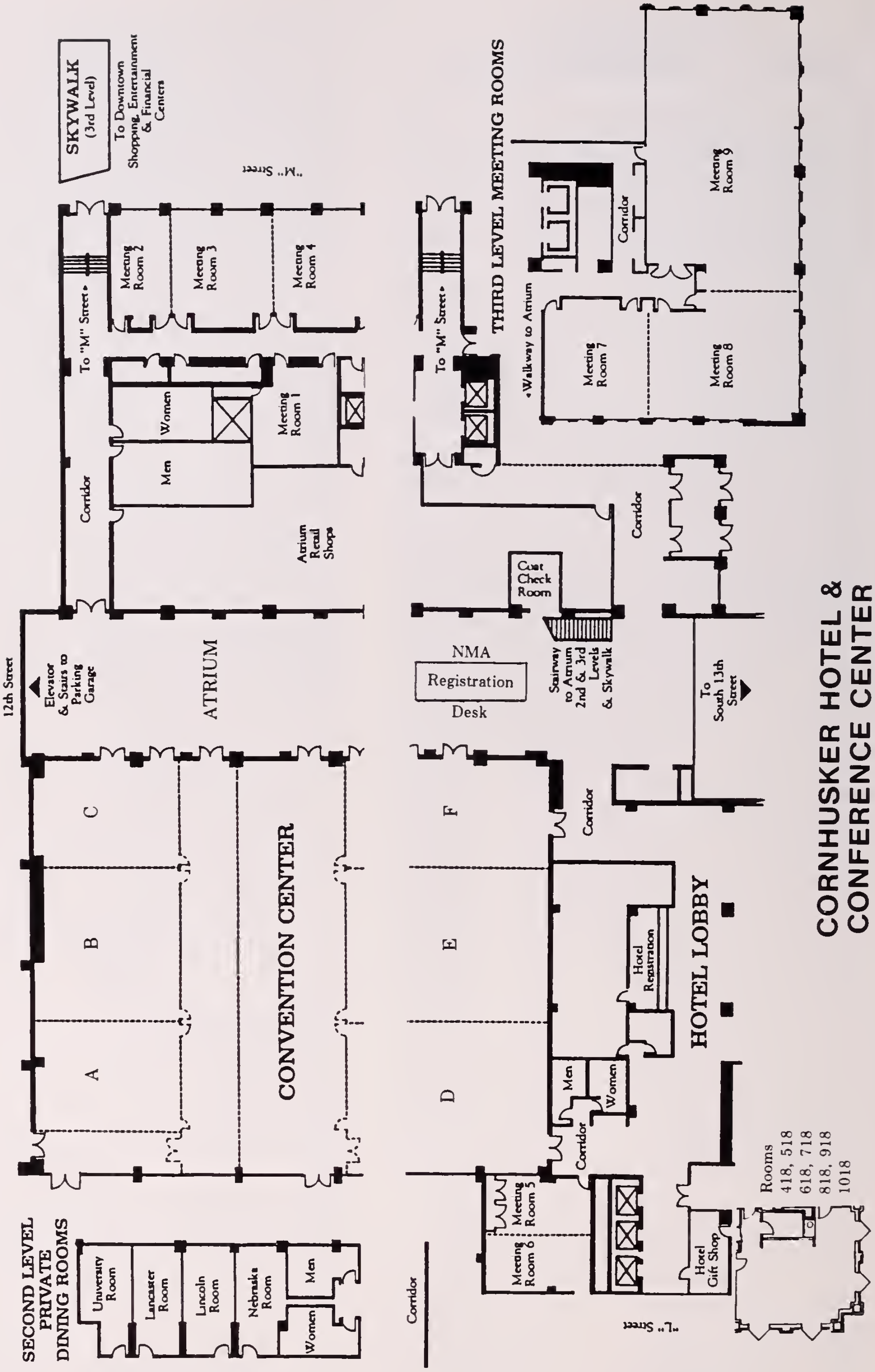
6:00 p.m. **Presidents' Reception** — Rooms A, B, & C
Honoring the President of the Nebraska Medical Association and the President of the Nebraska Medical Association Auxiliary

7:00 p.m. **Inaugural Banquet** — Rooms D, E & F
Installation of Francis D. Donahue, M.D.

If We Don't Care, Who Does?
Joseph F. Boyle, M.D., President
American Medical Association
Los Angeles, California

Past Presidents
Nebraska Medical Association

Gilbert C. Monell, M.D., Omaha	1868-69
James H. Peabody, M.D., Omaha	1869-70
N. B. Larsh, M.D., Nebraska City	1870-71
R. R. Livingston, M.D., Plattsmouth	1871-72
A. Bowen, M.D., Nebraska City	1872-73
H. P. Mathewson, M.D., Omaha	1873-74
John Black, M.D., Plattsmouth	1874-75
L. H. Robbins, M.D., Lincoln	1875-76
J. P. Peck, M.D., Omaha	1876-77
L. J. Abbott, M.D., Fremont	1877-78
E. M. Whitten, M.D., Nebraska City	1878-79
Harvey Link, M.D., Millard	1879-80
S. D. Mercer, M.D., Omaha	1880-81
M. W. Stone, M.D., South Omaha	1881-82
A. H. Sowers, M.D., Lincoln	1882-83
Victor H. Coffman, M.D., Omaha	1883-84
F. G. Fuller, M.D., Grand Island	1884-85
W. W. Knapp, M.D., Lincoln	1885-86
Richard C. Moore, M.D., Omaha	1886-87
George H. Peebles, M.D., Lincoln	1887-88
Milton Lane, M.D., Kearney	1888-89
J. C. Denise, M.D., Omaha	1889-90
D. A. Walden, M.D., Beatrice	1890-91
Charles Inches, M.D., Scribner	1891-92
M. L. Hildreth, M.D., Lyons	1892-93
A. S. von Mansfelde, M.D., Ashland	1893-94
H. B. Lowry, M.D., Lincoln	1894-95
J. E. Summers, M.D., Omaha	1895-96
F. D. Haldeman, M.D., Ord	1896-97
Wilson O. Bridges, M.D., Omaha	1897-98
A. R. Mitchell, M.D., Lincoln	1898-99
Robert McConaughy, M.D., York	1899-00
H. M. McClanahan, M.D., Omaha	1900-01
Wm. B. Eby, M.D., Ainsworth	1901-02
A. B. Anderson, M.D., Pawnee City	1902-03
B. F. Crummer, M.D., Omaha	1903-04
R. C. McDonald, M.D., Fremont	1904-05
A. F. Jonas, M.D., Omaha	1905-06
F. A. Long, M.D., Madison	1906-07
Harold Gifford, M.D., Omaha	1907-08
L. M. Shaw, M.D., Osceola	1908-09
P. H. Salter, M.D., Norfolk	1909-10
J. P. Lord, M.D., Omaha	1910-11
A. D. Nesbit, M.D., Tekamah	1911-12
I. N. Pickett, M.D., Odell	1912-13
D. C. Bryant, M.D., Omaha	1913-14
J. P. Gilligan, M.D., O'Neill	1914-15
E. W. Rowe, M.D., Lincoln	1915-16
W. F. Milroy, M.D., Omaha	1916-17 (to 12-31-17)
C. L. Mullins, M.D., Broken Bow	1918
J. M. Bannister, M.D., Omaha	1919
H. W. Orr, M.D., Lincoln	1920
M. S. Moore, M.D., Gothenburg	1921
B. B. Davis, M.D., Omaha	1922
B. F. Bailey, M.D., Lincoln	1923
Morris Nielsen, M.D., Blair	1924
Palmer Findley, M.D., Omaha	1925
H. J. Lehnhoff, M.D., Lincoln	1926
H. E. Potter, M.D., Fairbury	1927
B. R. McGrath, M.D., Grand Island	1928-29 (to 5-14-29)
F. S. Owen, M.D., Omaha	1929-30
K. S. J. Hohlen, M.D., Lincoln	1930-31
Lucien Stark, M.D., Norfolk	1931-32
A. E. Cook, M.D., Randolph	1932-33
Adolph Sachs, M.D., Omaha	1933-34
Joseph Bixby, M.D., Geneva	1934-35
Claude A. Selby, M.D., North Platte	1935-36
George W. Covey, M.D., Lincoln	1936-37
R. W. Fouts, M.D., Omaha	1937-38
Homer Davis, M.D., Genoa	1938-39
A. L. Miller, M.D., Kimball	1939-40
Clayton F. Andrews, M.D., Lincoln	1940-41
W. P. Wherry, M.D., Omaha	1941-42
Dexter D. King, M.D., York	1942-43
A. L. Cooper, M.D., Scottsbluff	1943-44
Floyd L. Rogers, M.D., Lincoln	1944-45
Charles McMartin, M.D., Omaha	1945-46
Earle G. Johnson, M.D., Grand Island	1946-47
G. E. Charlton, M.D., Norfolk	1947-48
J. E. M. Thomson, M.D., Lincoln	1948-49
J. D. McCarthy, M.D., Omaha	1949-50
C. H. Sheets, M.D., Cozad	1950-51
D. B. Steenburg, M.D., Aurora	1951-52
Harold S. Morgan, M.D., Lincoln	1952-53
James F. Kelly, M.D., Omaha	1953-54
Earl F. Leininger, M.D., McCook	1954-55
Wm. E. Wright, M.D., Creighton	1955-56
J. M. Woodward, M.D., Lincoln	1956-57
R. Russell Best, M.D., Omaha	1957-58
Fay Smith, M.D., Imperial	1958-59
E. E. Koebbe, M.D., Columbus	1959-60
Fritz Teal, M.D., Lincoln	1960-61
A. J. Offerman, M.D., Omaha	1961-62
O. A. Kostal, M.D., Hastings	1962-63
R. F. Sievers, M.D., Blair	1963-64
R. E. Garlinghouse, M.D., Lincoln	1964-65
Willis D. Wright, M.D., Omaha	1965-66
Dan A. Nye, M.D., Kearney	1966-67
Robert J. Morgan, M.D., Alliance	1967-68
Frank H. Tanner, M.D., Lincoln	1968-69
J. Whitney Kelley, M.D., Omaha	1969-70
Clarence R. Brott, M.D., Beatrice	1970-71
Roger D. Mason, M.D., McCook	1971-72
Frank P. Stone, M.D., Lincoln	1972-73
John D. Coe, M.D., Omaha	1973-74
James H. Dunlap, M.D., Norfolk	1974-75
Warren G. Bosley, M.D., Grand Island	1975-76
Harlan L. Papenfuss, M.D., Lincoln	1976-77
Arnold W. Lempka, M.D., Omaha	1977-78
Houtz G. Steenburg, M.D., Torrington, Wyo.	1978-79
Charles W. Landgraf, Jr., M.D., Hastings	1979-80
Russell L. Gorthey, M.D., Lincoln	1980-81
Carlyle E. Wilson, Jr., M.D., Borrego Springs, CA	1981-82
Allan C. Landers, M.D., Scottsbluff	1982-83
Dwaine J. Peetz, M.D., Neligh	1983-84



CORNHUSKER HOTEL & CONFERENCE CENTER

fore prescribing, see complete prescribing information in SK&F CO.
rature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ntraindications: Concomitant use with other potassium-sparing agents
:h as spironolactone or amiloride. Further use in anuria, progressive
al or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
assium. Hypersensitivity to either component or other sulfonamide-
ived drugs.

**rnings: Do not use potassium supplements, dietary or otherwise, unless
okalemia develops or dietary intake of potassium is markedly impaired.**
upplementary potassium is needed, potassium tablets should not be
ed. Hyperkalemia can occur, and has been associated with cardiac irregu-
ties. It is more likely in the severely ill, with urine volume less than
liter/day, the elderly and diabetics with suspected or confirmed renal
ufficiency. Periodically, serum K^+ levels should be determined. If hyper-
emia develops, substitute a thiazide alone, restrict K^+ intake. **Asso-
ted widened QRS complex or arrhythmia requires prompt additional
rapy.** Thiazides cross the placental barrier and appear in cord blood.
e in pregnancy requires weighing anticipated benefits against possible
ards, including fetal or neonatal jaundice, thrombocytopenia, other
erse reactions seen in adults. Thiazides appear and triamterene may
ear in breast milk. If their use is essential, the patient should stop
sing. Adequate information on use in children is not available. Sensitivity
ctions may occur in patients with or without a history of allergy or
nchial asthma. Possible exacerbation or activation of systemic lupus
thematosus has been reported with thiazide diuretics.

cautions: The bioavailability of the hydrochlorothiazide component of
azide' is about 50% of the bioavailability of the single entity. Theoreti-
ly, a patient transferred from the single entities of Dyrenium (triamterene,
&F CO.) and hydrochlorothiazide may show an increase in blood pressure
fluid retention. Similarly, it is also possible that the lesser hydro-
orothiazide bioavailability could lead to increased serum potassium levels.
wever, extensive clinical experience with 'Dyazide' suggests that these
ditions have not been commonly observed in clinical practice. Do
iodic serum electrolyte determinations (particularly important in patients
niting excessively or receiving parenteral fluids, and during concurrent
with amphotericin B or corticosteroids or corticotropin [ACTH]).
iodic BUN and serum creatinine determinations should be made,
ecially in the elderly, diabetics or those with suspected or confirmed
al insufficiency. Cumulative effects of the drug may develop in patients
h impaired renal function. Thiazides should be used with caution in
ients with impaired hepatic function. They can precipitate coma in
ients with severe liver disease. Observe regularly for possible blood
crasias, liver damage, other idiosyncratic reactions. Blood dyscrasias
e been reported in patients receiving triamterene, and leukopenia,
ombocytopenia, agranulocytosis, and aplastic and hemolytic anemia
e been reported with thiazides. Thiazides may cause manifestation of
ent diabetes mellitus. The effects of oral anticoagulants may be
reased when used concurrently with hydrochlorothiazide; dosage adjust-
nts may be necessary. Clinically insignificant reductions in arterial
ponsiveness to norepinephrine have been reported. Thiazides have also
en shown to increase the paralyzing effect of nondepolarizing muscle
xants such as tubocurarine. Triamterene is a weak folic acid antagonist.
periodic blood studies in cirrhotics with splenomegaly. Antihypertensive
ects may be enhanced in post-sympathectomy patients. Use cautiously
surgical patients. Triamterene has been found in renal stones in asso-
tion with the other usual calculus components. Therefore, 'Dyazide'
uld be used with caution in patients with histories of stone formation.
ew occurrences of acute renal failure have been reported in patients on
azide' when treated with indomethacin. Therefore, caution is advised in
ninistering nonsteroidal anti-inflammatory agents with 'Dyazide'. The
owing may occur: transient elevated BUN or creatinine or both, hyper-
cemia and glycosuria (diabetic insulin requirements may be altered),
eruricemia and gout, digitalis intoxication (in hypokalemia), decreasing
ali reserve with possible metabolic acidosis. 'Dyazide' interferes with
rescent measurement of quinidine. Hypokalemia is uncommon with
azide', but should it develop, corrective measures should be taken such
potassium supplementation or increased dietary intake of potassium-
foods. Corrective measures should be instituted cautiously and serum
assium levels determined. Discontinue corrective measures and
azide' should laboratory values reveal elevated serum potassium.
oride deficit may occur as well as dilutional hyponatremia. Concurrent
with chlorpropamide may increase the risk of severe hyponatremia.
rum PBI levels may decrease without signs of thyroid disturbance. Cal-
m excretion is decreased by thiazides. 'Dyazide' should be withdrawn
ore conducting tests for parathyroid function.

azides may add to or potentiate the action of other antihypertensive
gs.

retics reduce renal clearance of lithium and increase the risk of lithium
icity.

verse Reactions: Muscle cramps, weakness, dizziness, headache, dry
uth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermat-
gical conditions; nausea and vomiting, diarrhea, constipation, other
strointestinal disturbances; postural hypotension (may be aggravated by
ohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias,
erus, pancreatitis, xanthopsia and respiratory distress including pneu-
nitis and pulmonary edema, transient blurred vision, sialadenitis, and
tigo have occurred with thiazides alone. Triamterene has been found in
al stones in association with other usual calculus components. Rare
idents of acute interstitial nephritis have been reported. Impotence has
en reported in a few patients on 'Dyazide', although a causal relationship
s not been established.

**pplied: 'Dyazide' is supplied as a red and white capsule, in bottles of
00 capsules; Single Unit Packages (unit-dose) of 100 (intended for
titutional use only); in Patient-Pak™ unit-of-use bottles of 100.**
S-DZ:L39

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When You Need to
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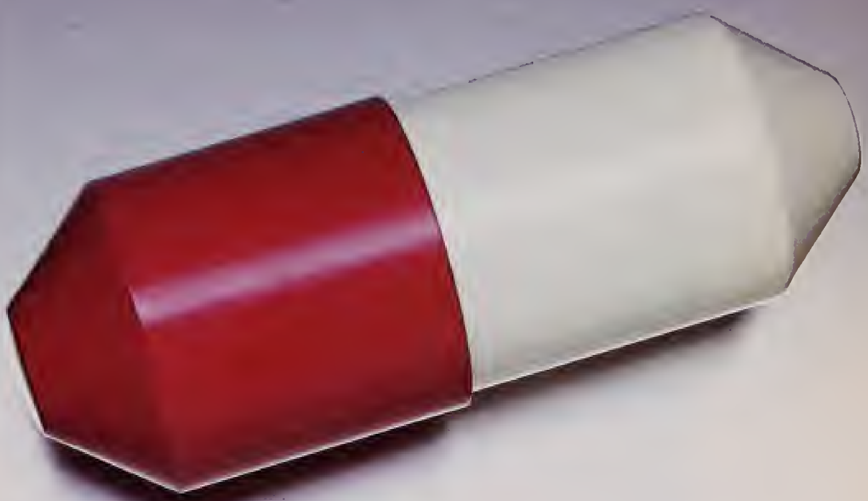
Remember the Unique
Red and White Capsule:
Your Assurance of
SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



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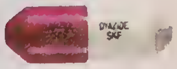

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On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

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So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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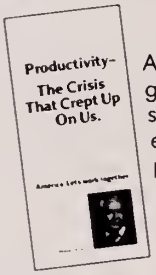
IGNORANCE IS NO EXCUSE.

America's declining productivity is serious business.

It's about time we all got serious about it.



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Medical Education Cuts Attacked

Medical educators and students say they are "outraged" by a Reagan Administration budget proposal that would "wipe out" federal support of health professions' education and congressional health staffers have told the Administration that the proposal is "politically impossible."

The widely-predicted provision in the just-released fiscal 1986 budget plan followed a Presidential veto of health manpower reauthorization legislation late last fall after Congress had adjourned. Conventional wisdom is that the veto might otherwise have been overridden, and committees with manpower jurisdiction are preparing to reintroduce manpower legislation.

The educational assistance programs the President seeks to terminate include grants for special training programs, assistance to financially disadvantaged and minority students and schools, and nurse training.

No new federal capital would be allocated for Health Professions Student Loans (HPSL), but an estimated $67 million in revolving loan funds administered through 1,400 health professions and nursing schools would remain in circulation. The current $250 million ceiling on Health Education Assistance Loans (HEAL) would be lowered to $100 million.

The budget proposal also would end the National Health Service Corps scholarship program and would reduce funds for NHSC members already in underserved communities by about a third — from $75 million in 1985 to $50 million in FY86. The budget cuts occur despite an expected increase in the number of NHSC practitioners in the field — from 3102 in 1985 to 3507 in 1986. Federal officials say the funding shortfall can be made up by continuing efforts to encourage more NHSC scholars to repay their obligation through private practice rather than as federal corpsmen.

In other manpower budget provisions, the maternal and child health block grant would be funded at its 1985 level of $478 million; funding for the Indian Health Service would be reduced by nearly $100 million; health planning funds would be eliminated and federal staff associated with manpower programs would be reduced by the equivalent of about 1000 full-time positions; a primary care block grant that currently offers an alternative to categorical funding for community health centers would be expanded and "probably" made mandatory.

In justifying the decision to end "federal subsidies" to the health professions, the budget documents point to a "projected national surplus" of physicians and nurses.

Representatives of the medical profession said, however, that the cuts in professional training support are exacerbated by proposed restrictions on guaranteed student loans for all students of higher education. The real impact of the proposal will be to influence the makeup of the medical student population and specialty and geographic distribution rather than to curtail the overall physician supply, they added. James H. Sammons, M.D., Executive Vice President of the American Medical Association, said the cuts could "endanger the quality of health care in the United States."

* * *

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FOR YOU
FOR A MEMBER OF YOUR FAMILY
FOR A PROFESSIONAL, FRIEND OR COLLEAGUE

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The Physician's Advocacy Committee
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Strictly Confidential — Professional — Effective

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(You do not have to give your name.)

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FAMILY PHYSICIAN: Needed now to join B/C F.P. in modern, superiorly-equipped clinic and adjoining hospital. Reason: Associate leaving. Call shared with the two other F.P.'s in this award winning community in west central Nebraska. Send C.V. to: Larry Wilson, M.D., 902 - 20th, Gothenburg, NE 69138.

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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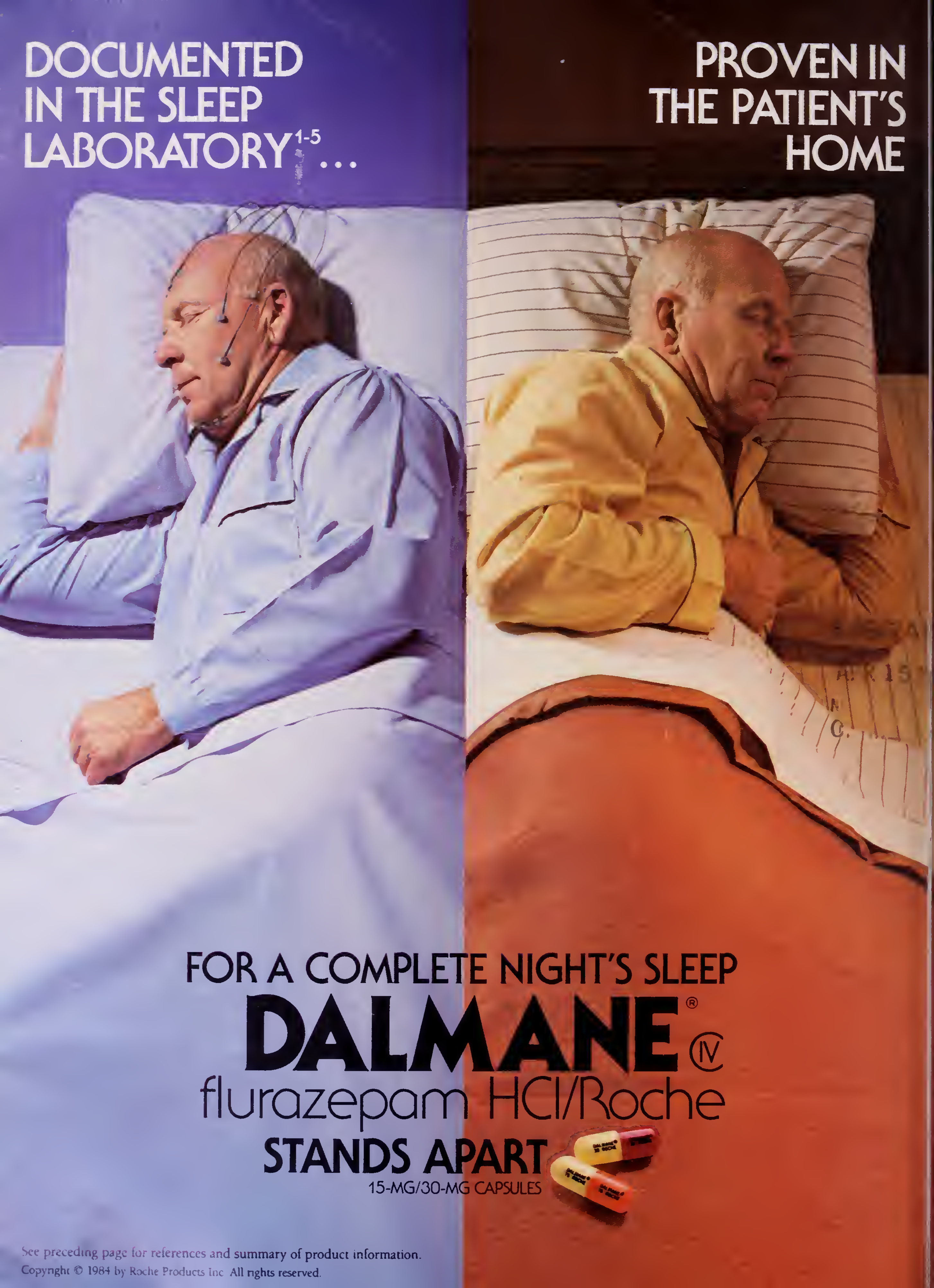
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VOL. 70, NO. 5 MAY 1985

THE NEBRASKA MEDICAL JOURNAL

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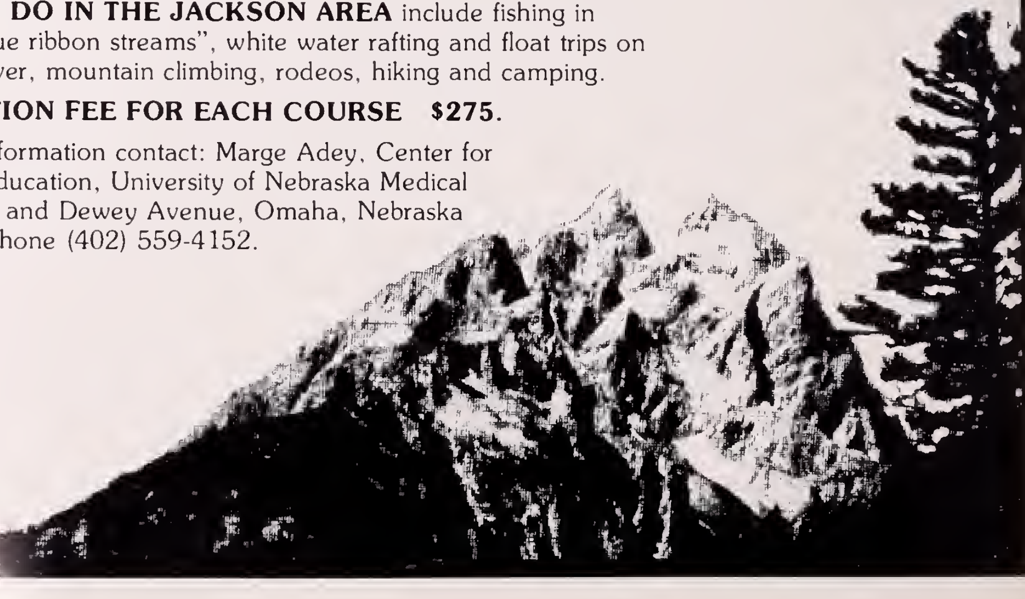

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Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg) Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg. for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2 5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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Review articles will be considered, and should generally be limited to less than 4,000 words and approximately 30 references.

Manuscripts describing original clinical or laboratory research should be limited to 2,000 words and approximately 20 references.

Acknowledgements must be given when material from other publications is included. Provide names of authors, title of article, title of journal or book, volume number, pages, month and year, and publisher's permission to reprint.

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National Health Policy Group Recommended

The Catholic Health Association has urged President Reagan and Congress to create a 15-member national commission on health policy.

CHA President John Curley told the Washington press corps that the commission's goal would be to "stop the nation's reliance on short-sighted, stop-gap measures that control health care costs without solving the problems that escalate costs."

Commission members, who would serve for three years, would be picked up President Reagan, the Speaker of the House and the President pro tempore of the Senate. Each would name five members consisting of a physician, a health care administrator, another health professional and two members from other fields such as insurance, labor, law, and business.

* * *

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WashingtoNotes

Despite HCFA Budget Cuts, Physician DRG Studies Continue

Federally-funded research into physician payment options will continue despite President Reagan's proposal to cut Medicare-and-Medicaid-related research funds by a third in the fiscal 1986, Health Care Financing Administration officials say.

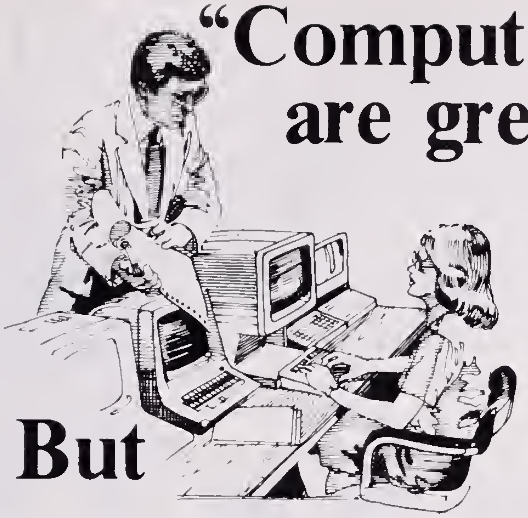
The proposal to cut HCFA's research and demonstration budget from $33 million in fiscal 1985 to $22 million in fiscal 1986 would force the agency to scale back on studies in some other areas, however. It could also curtail research in the remainder of 1985.

If accepted by Congress, the budget reductions would come just as HCFA officials are struggling to complete a host of congressionally-mandated studies on the extension and refinement of Medicare's diagnostic-related groups (DRGs) payments for hospitals. Some studies, including one on the treatment of capital costs in DRG payments, are already overdue. Others, such as a recommendation on the "advisability and feasibility" of extending DRGs to inpatient physician services, have had the deadline moved up — from December 31, 1985 to July 31.

As a result, HCFA Administrator Carolyne Davis, PhD, told reporters at a budget briefing that the 1986 budget recommendation would require the agency to "target" its research efforts on physician payment and the extension of prospective pricing to other parts of the system. Although the research reductions can be justified as part of a larger effort to trim the federal deficit, she added, the cuts do represent a "definite shift."

The announcement of the fiscal 1986 budget request coincided with a solicitation of bids for Medicare and Medicaid studies and demonstrations to be funded in the remainder of 1985. Carried in the January 30 Federal Register, the solicitation outlines areas in which HCFA has an interest and signals the Administration's desire to move away from a system that depends on the number of services provided to one that limits the government's liability to some predetermined amount.

(Continued on page 12A)



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(Continued from page 11A)

One area in which HCFA is "extremely interested," the solicitation says, is "reforming physician payment methods." Demonstrations could involve the examination of the impact of a Medicare voucher on physician participation, incomes, specialty and location. Or they might center on prospective payments for physicians.

Prospective payment might combine hospital and physician payments, it suggests, or it might package all physician services through areawide budgets, competitive bidding, preferred provider organizations, or risk-sharing with Medicare carriers such as Blue Shield plans.

Other studies of interest to HCFA include those aimed at: finding a better way to adjust within DRGs for differences in the severity of

(Continued on page 187)

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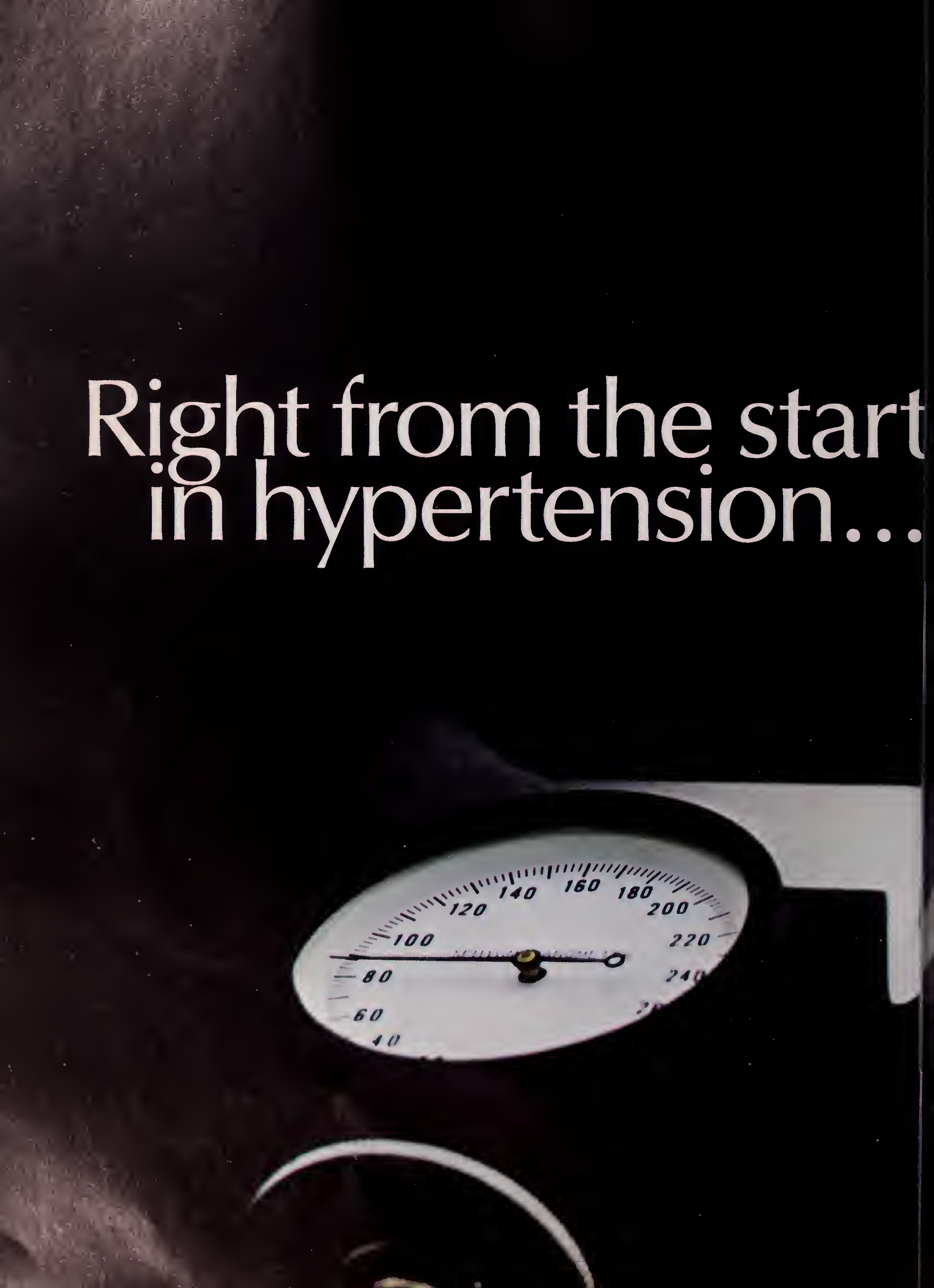
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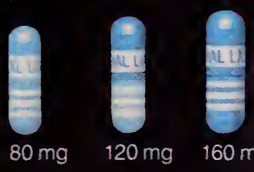

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BRIEF SUMMARY *FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)*

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic inotropic and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension it may be used alone or used in combination with other antihypertensive agents particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina palpitations and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE continued use of beta blockers can in some cases, lead to cardiac failure Therefore at the first sign or symptom of heart failure the patient should be digitalized and/or treated with diuretics, and the response observed closely or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and in some cases myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted however that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g dobutamine or isoproterenol However such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME several cases have been reported in which, after propranolol the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice employing doses up to 150 mg/kg/day there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular bradycardia congestive heart failure, intensification of AV block hypotension, paresthesia of hands, thrombocytopenic purpura arterial insufficiency, usually of the Raynaud type

Central Nervous System lightheadedness; mental depression manifested by insomnia lassitude weakness fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place short-term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting epigastric distress, abdominal cramping diarrhea constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous, alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L. Diuretic-induced ventricular ectopic activity *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984,251.1298-1299.

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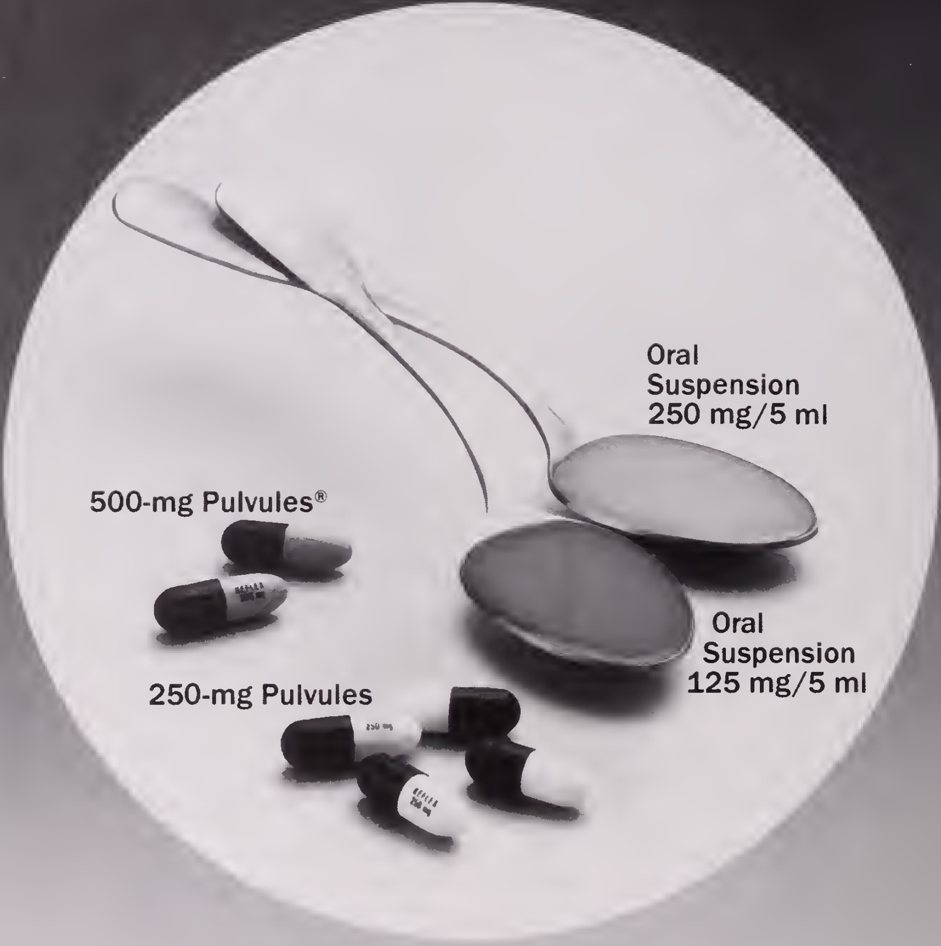

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THE NEBRASKA MEDICAL JOURNAL

Pulmonary Embolism and Monitoring Pulmonary Artery Pressures

In this issue of the **Nebraska Medical Journal,** Ornato, et.al., describes their retrospective study in monitoring pulmonary artery pressures in pulmonary embolism. They compare their retrospective findings in 11 patients versus 11 controls. Their main conclusion is that if the pulmonary artery diastolic pressure is 2mm Hg greater than the pulmonary artery wedge pressure recording, utilizing a Swan-Ganz catheter at the bedside, that pulmonary embolism is **one** of the clinical possibilities to be considered. This is one of the main points that needs to be re-emphasized: it is not diagnostic of pulmonary embolism, since other diseases can create a higher pulmonary artery diastolic pressure than mean wedge pressure, specifically diseases that elevate pulmonary arteriolar resistance, such as pulmonary fibrosis. Their control group included no patients with pulmonary fibrosis. The readers should further realize that using a sensitivity of 0.73, three of their 11 patients with presumably "major" emboli were not correctly identified. And, in actual clinical practice, at least in our clinical experience, it is very difficult to reproducibly identify differences of 2-3mm Hg between pulmonary artery diastolic and mean wedge pressure. Don't be confused by the authors' use of the description torr. One torr equals 1mm of mercury, and is a common term used in pulmonary and critical care medicine.

Finally, it should not be concluded after reading this article that a Swan-Ganz catheter is necessary to diagnose pulmonary embolization. Most likely, the majority of the patients in the above study have major pulmonary emboli, not minor to moderate degree of pulmonary embolization, the latter so frequently seen in clinical practice. The primary indication for a Swan-Ganz catheter would be when the clinical diagnosis is in doubt, and the patient is in severe hemodynamic difficulty, ie, shock. If a patient has a clinical setting suggestive for pulmonary embolization, following clinical examination and arterial blood gases, a ventilation-perfusion lung scan is the appropriate course of action. If that is still non-diagnostic, and you are questioning whether to use either intravenous heparin or intravenous streptokinase, then a pulmonary angiogram is still the diagnostic procedure of choice, not passage of a Swan-Ganz catheter.

So, if you personally monitor pulmonary pressures after inserting Swan-Ganz catheters, and find a discrepancy between the pulmonary diastolic and mean wedge pressure, one of the things you should consider is pulmonary embolization. A difference of 2-3mm Hg may arouse suspicion of pulmonary emboli, but it certainly is not diagnostic.

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The Difference Between Pulmonary Artery Diastolic Pressure and Pulmonary Capillary Wedge Pressure as a Hemodynamic Sign of Pulmonary Embolism

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PULMONARY artery diastolic pressure (PAd) usually closely approximates publmonary capillary wedge pressure (PCw) due to the high-capacitance, low-resistance characteristics of the normal pulmonary vascular bed.[1,2,3,4] Certain abnormal physiological or pathological states can alter this relationship. For example, rapid atrial pacing at rates above 115 to 124 beats per minute increases PAd and decreases PCw resulting a consistent disparity (averaging +11 mm Hg) between these two pressures.[5,6] Left ventricular dysfunction has the opposite effect, causing the PAd to underestimate left ventricular filling pressure.[5,7]

Elevation of pulmonary vascular resistance can also change the relationship between the PAd and PCw. In animals, experimental acute pulmonary embolization elevates pulmonary vascular resistance (PVR) and is accompanied by a high PAd and a low or normal PCw.[8] This hemodynamic clue to the presence of pulmonary embolism (PE) in patients has been repeatedly cited in the literature without reference to substantiating evidence of the sign's validity in humans.[1,2,9,11]

We compared hemodynamic data from 11 patients who had angiographically or autopsy proven pulmonary embolism with 11 age and sex matched patients who had no evidence of emboli clinically and at autopsy to determine the validity of the (PAd-PCw) difference as a clinical sign of pulmonary embolization.

Methods:

Cases were located by searching the University of Nebraska Hospital computer file of discharge diagnostic and procedure codes from 1980 through 1983. The study population consisted of patients with PE documented by pulmonary angiography or autopsy who had immediately sequential measurement of pulmonary artery diastolic and pulmonary capillary wedge pressures using a flow-directed pulmonary artery catheter or during pulmonary angiography. Controls were age and sex matched patients who had immediately sequential PAd and PCw recordings using a flow-directed pulmonary artery catheter and who had no evidence of PE clinically and at autopsy.

Pressures were recorded using a Hewlitt-Packard Model 01280-68100 CD9 transducer attached to a H-P 78205D pressure module. The first set of recordings after the PE occurred clinically but prior to anticoagulation was chosen for analysis. If the clinical time of embolization was unclear, the first set of recordings after insertion of the pulmonary artery flow-directed catheter was chosen. Pressures are expressed in torr (1 torr = 1 mm Hg).

Our null hypothesis was that there was no significant difference in (PAd-PCw) between the study population and the controls. Student's t-test was used to test this hypothesis. Standard z-scores were used to determine the 95% confidence interval for the difference in (PAd-PCw) pressure in the study and control groups. Chi square was used to test the ability of the PAd-PCw value to discriminate between patients with PE and those without.

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Results:

Table 1 contains case summaries for the study population and controls. There was no statistically significant difference in age, pulmonary artery systolic or diastolic pressure, pulmonary vascular resistance, pulmonary capillary wedge pressure, pulse rate, systemic systolic blood pressure, or cardiac output between the two groups. There was a significantly greater difference between PAd and PCw in patients with PE than in controls ($P < .005$). The 95% confidence interval for the (PAd-PCw) value was -2.3 to +1.8 torr in controls and +2.1 to +6.5 in patients with PE.

We chose +2.0 torr as a boundary for the (PAd-PCw) value between controls and patients with proven PE. Using this limit, 8 of 11 patients with PE were correctly identified (specificity=0.73). This boundary statistically significantly distinguished patients from controls ($P < 0.03$). Changing the limit to +5.0 torr decreased sensitivity to 0.36 and increased specificity to 0.91. A limit of +8.0 torr dropped sensitivity to 0.18 but increased specificity to 1.00.

Discussion:

Acute elevation of pulmonary artery mean pressure (PAm) and PVR have been documented in patients with angiographically proven pulmonary embolism.[10] These findings, which persist for about two weeks, closely parallel changes noted in animals following experimental embolization of the pulmonary arterial tree.[10] Our study confirms that the positive (PAd-PAw) difference noted in animals is also present in patients with proven PE. This difference was sufficient in magnitude to distinguish such individuals from patients who require hemodynamic monitoring but have no clinical or autopsy evidence of PE.

Authors citing the usefulness of a positive (PAd-PCw) value as a sign of PE disagree on the cutoff point above which PE should be considered. Some have apparently arbitrarily chosen a five[11] or eight[1] torr difference as a

TABLE 1: SUMMARY OF PATIENT DATA

PAs = pulmonary artery systolic pressure in torr, PAD = pulmonary artery diastolic pressure in torr, Diff = PAd - PCw in torr, PAm = pulmonary artery mean pressure in torr, PVR = pulmonary vascular resistance in dynes-sec-cm$_{-5}$, BPs = systolic blood pressure in torr, CO = cardiac output in L/min, TIME = time between occurrence of P.E. & placement of Swan-Ganz catheter, #EMB = number of emboli. ARDS = acute respiratory distress syndrome, CAD = coronary artery disease, CHF = congestive heart failure, CVA = cerebrovascular accident, COPD = chronic obstructive pulmonary disease.

Patients with proven pulmonary embolism

#	DATE	AGE	SEX	PAs	PAd	PCw	Diff	PAm	PVR	PULSE	BPs	CO	TIME	# EMB	SIZE	LOCAT	OUTCOME	DIAGNOSIS
1	10/80	14	m	50	20	20	0	30	-	120	120	-	12 hr	mult	large	bilat	lived	Panhypopituitarism
2	4/81	66	m	41	26	22	4	31	300	105	106	2.4	unkn	mult	small	left	died	CAD, CHF, COPD
3	5/81	80	m	25	23	22	1	30	145	-	90	4.4	unkn	single	med	right	died	CAD
4	6/81	59	f	33	22	19	3	25	94	100	160	5.1	4 dy	mult	med	right	lived	Pericard effusion
5	8/81	69	f	70	43	30	13	51	542	-	128	3.1	unkn	single	med	right	died	CAD, CHF
6	2/82	74	f	60	33	26	7	41	273	56	122	4.4	4 dy	mult	small	bilat	lived	CVA
7	3/82	76	m	40	18	13	5	23	-	82	80	-	unkn	mult	large	bilat	died	CHF, aspir pneumonia
8	6/82	66	m	22	10	7	3	16	73	114	110	9.9	4 hr	mult	small	bilat	died	CHF, sepsis
9	11/82	76	f	32	12	4	8	22	253	96	112	5.7	16 dy	mult	small	bilat	died	ARDS
10	2/83	75	m	54	13	12	1	24	223	100	110	4.3	48 hr	single	small	right	died	Metast adenoca
11	2/83	65	m	48	24	22	2	34	-	72	100	-	unkn	mult	small	bilat	lived	CAD
MEAN		65.5		43.2	22.2	17.9	4.3	29.7	237.9	93.9	112.5	4.9						
STD DEV		18.2		14.9	9.6	8.0	3.8	9.7	148.6	20.4	21.0	2.3						

Control patients without pulmonary emboli clinically and at autopsy

#	DATE	AGE	SEX	PAs	PAd	PCw	Diff	PAm	PVR	PULSE	BPs	CO	DIAGNOSIS
1	11/80	55	f	51	27	32	-5	37	114	92	80	3.5	CAD, CHF
2	11/81	66	m	46	12	18	-6	24	75	-	124	6.4	CAD
3	1/82	77	m	32	17	17	0	23	109	75	140	4.4	Superior mesenteric artery occlusion
4	1/82	81	m	20	12	11	1	15	62	115	90	5.2	CAD
5	2/82	59	f	35	15	16	-1	24	131	96	125	4.9	Meningitis
6	3/82	69	f	57	10	14	-4	37	736	146	80	2.5	CAD, CHF, pneumonia
7	6/82	70	f	52	22	23	-1	38	141	-	72	8.5	Hypovolemic shock
8	9/82	74	m	29	5	3	2	13	121	132	82	6.6	ARDS, abdominal abscess
9	2/83	67	m	36	22	21	1	30	138	93	96	5.2	CAD
10	3/83	64	m	30	20	18	2	23	98	108	134	4.1	CAD, sepsis
11	4/83	79	m	48	20	13	7	31	306	70	84	4.7	Ca colon, sepsis
MEAN		69.2		39.6	16.5	16.9	-0.4	26.8	184.7	103.0	100.6	5.1	
STD DEV		8.2		11.7	6.4	7.3	3.7	8.6	193.7	25.0	25.0	1.6	
SIGNIF		NS		NS	NS	NS	<.005	NS	NS	NS	NS	NS	

boundary. Our data indicate that patients with a PAd more than +2.0 torr above PCw should be suspected of having a PE. Raising the cutoff to five or eight torr increase the sign's specificity but markedly reduce its sensitivity.

Although helpful, this sign is not diagnostic of PE. Other conditions which increase PVR such as intracardiac shunts,[3] pulmonary fibrosis,[1] or rapid infusion of banked blood[4] may cause a similar hemodynamic pattern.

Pulmonary hypertension (PAm > 20 torr) is found in more than 60 percent of patients who have at least 25-35 percent of their pulmonary vascular bed occluded with emboli.[10,12,13,14, 15] Although nearly universal in our patients with PE[10,11], pulmonary hypertension was also common in our matched controls,[9,11] reflecting the life-threatening medical problems of that group. The elevation in PVR in our patients with PE was similar to that of patients in the National Urokinase-Pulmonary Embolism study.[12] Approximately 80 percent of patients in that study had a PVR above 200 dynes-sec-cm.[5] In our study 5/8 patients (62.5 percent) with PE had a PVR above, and 9/11 controls (81.9 percent) had a PVR below, this limit. Pulmonary hyptertension was a poor discriminator of PE in our study. The (PAd-PCw) difference appeared to be a more specific marker for PE.

Other factors which alter the (PAd-PCw) difference may lessen the accuracy of this sign. Tachycardia, with rates above 115 to 125 beats per minute, can falsely increase the (PAd-PCw) difference.[5,6] In our study, there was no significant difference in pulse rate at the time of measurement between patients with PE and controls. Both groups had a mean heart rate below the 115 beat per minute limit. Quintana[15] has shown that occlusion of the pulmonary artery distal to the tip of the recording catheter in dogs can cause the pressure tracing to resemble a damped, falsely lowered pulmonary artery curve. Recording from such an area in humans could also falsely decrease the (PAd-PCw) difference. Concomitant left ventricular dysfunction may also narrow the (PAd-PCw) gradient.[5,7,16] Although PE patients without other underlying cardiovascular disease usually have a normal PCw pressure,[13] many of our patients and controls had other concomitant problems causing left ventricular dysfunction.

Several limitations of this study bear mention. First, the precise time of embolization could not be determined in 5 of 11 patients. It is therefore possible that embolization occurred after the pulmonary artery catheter was inserted. This is not very likely since the catheter was usually inserted for management of a hemodynamically unstable state, probably created by the PE. Second, we have no data indicating the duration of the positive (PAd-PCw) difference following embolization. It is likely to be several days to two weeks, based on Dalen's[10] findings. Third, our sample size is not large enough to be divided into massive and submassive PE subgroups for further analysis. This would have been helpful in light of Riedel's[13] finding that severe chronic pulmonary hypertension (PAm above 30 torr) does not occur in patients after a single episode of acute PE, is infrequent after single subacute or recurrent emboli, and is common after occult emboli. We cannot tell if the positive (PAd-PCw) difference is more common with larger or recurrent emboli than with smaller or single clots.

Although our study indicates that a +2.0 torr difference between the (PAd-PCw) identifies many patients with recent PE, caution should be observed in patients with a (PAd-PCw) value close to this cutoff. Our recording equipment automatically calculated the PAd and PCw and digitally displayed the result which was then recorded by a nurse or physician. Without such technology, observer error or variability in estimating these pressures may alter the sensitivity and specificity of this sign.

Our study validates the (PAd-PCw) value as a hemodynamic sign of PE. This clue should arouse suspicion of emboli and, where clinically appropriate, be followed-up by a more definitive search.

Summary:

Pulmonary artery diastolic pressure (PAd) normally approximates pulmonary capillary wedge pressure (PCw), except when tachycardia, left ventricular dysfunction, or increased pulmonary vascular resistance is present. In animal models, pulmonary embolization causes the PAd to elevate while a normal PCw is maintained, resulting in a positive PAd-PCw gradient. We compared hemodynamic data from 11 patients who had angiographically or

autopsy proven pulmonary emboli (PE) with 11 age and sex matched patients who had no evidence of emboli clinically at autopsy to determine the validity of the PAd-PCw value as a clinical hemodynamic sign of PE. We found that a PAd-PCw value of greater than +2.0 torr is a moderately reliable (sensitivity=0.73, specificity=0.73) indicator of pulmonary embolization.

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Laser Endoscopy

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THE development of the Nd-YAG (neodymium-yttrium aluminum garnet) laser, the first laser that is flexible and can be passed through an endoscope while retaining the power to vaporize tumors and coagulate bleeding vessels, is an exciting addition to the field of endoscopy. Although this modality is in its infancy stage, it has already found many applications in the fields of pulmonology and gastroenterology. We will first review lasers in general and then discuss specific uses in these fields.

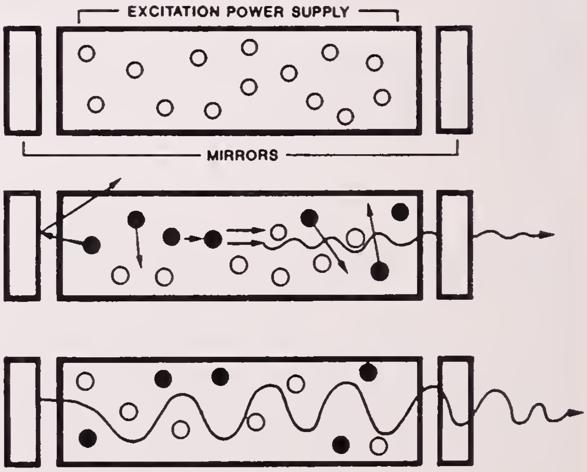
Laser, an acronym of **L**ight **A**mplification by **S**timulated **E**mission of **R**adiation, refers to a device which produces a beam of electromagnetic energy. The laser beam has a unique characteristic in that it is coherent in perfect phase rather than diffuse as normal light. Since all of the rays are parallel and of the same wave length, this makes the laser a very narrow, high powered source of energy which can be focused by a series of lenses. When it is focused on tissue, it is absorbed causing a localized temperature increase, resulting in coagulation and/or vaporization.

Albert Einstein first postulated the mechanism for laser beam production. An electron can exist in only one of a certain number of orbits around a positively charged nucleus, and this is determined by the energy level that represents the stable state for each type of atom. If an atom is struck by an electron containing energy higher than the atom's own electron, it is possible for some of that energy to be transferred to the atom. (The electron is transferred to a different, higher orbit.) When the electron returns from this high energy level to a lower one, electromagnetic radiation is emitted following one of three principles, as described by Einstein: (1) spontaneous emission, (2) absorption, or (3) stimulated emission. If an atom in the excited state is struck by an electron of exactly the same energy as the electron to be emitted, then the emission would be stimulated to occur sooner, causing two electrons of the same energy level to leave the atom, both traveling in exactly the same direction with the same wave length -- a laser beam.

A laser cavity consists of two parallel mirrors enclosing the laser medium and excited by the power supply. (Figure 1) After the medium is pumped to achieve a population inversion (more cells in the excited state than in the stable state), the atoms will emit electrons spontaneously in all directions. A great deal of the emissions will propagate away from the cavity and are lost as heat; a small fraction travel perpendicular to the mirrors, stay in the cavity and provide the source for the stimulated emission. The light is coherently amplified by the mirrors which causes more stimulated emission of in-phase electrons with excited atoms. The net result is an intense beam of coherent radiation. The active medium, the mirror, reflectors, and the pumping element, are referred to as the "oscillator."

The laser is known to act on living tissues by two mechanisms: (1) thermal effects, and (2)

FIGURE 1



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*Please address all correspondence and/or reprint requests to Dr. Smith photochemical effects. Most applications of lasers in the medical field have been based on the thermal effects, which correspond to a rise in the temperature brought about by a transformation of absorbed light energy into heat. The depth of penetration depends on the type of tissue involved, its pigmentation and vascular content, the wave length of the laser itself, and distance from the target. In addition to its thermal effects, there are some promising results when the laser is used for its photochemical effects. The treatment consists of a two to three day series of injections of a suitable dye (usually hematoporphyrine derivative - HPD). The dye is eliminated more quickly by healthy cells than cancer cells and the cancer cells thus become labeled. These can be visualized by fluorescence and irradiated with a YAG laser, which induces a photochemical reaction destroying the HPD labeled cells.

The Nd-YAG laser is only moderately absorbed and therefore has deeper penetration. It is best known for its coagulation properties and not vaporization. It can also be transmitted by water and therefore is effectively used, for example, in the treatment of bladder cancers by transmission through a water or urine filled bladder.

In pulmonary medicine, the indications for laser therapy are multiple and will be expanded considerably over the next few years as we learn more about this treatment modality. (Table 1) At the present time in bronchology, laser therapy is best suited for removal of tracheal, mainstem, or lobar obstruction causing respiratory distress and hypoxemia and/or obstructive pneumonia.

Malignancies in the tracheobronchial tree often obstruct major airways, either as a tumor that arises endobronchially or as an extrabronchial tumor that extends into the tracheobronchial tree. Treatment choices at the present time include surgery (based on cell type and tumor location) or irradiation and/or chemotherapy. Although these modalities may give early amelioration, the risk for tumor recurrence is high and there is a limit as to the amount of treatment a patient can receive with radiation or chemotherapy. There is no alternative treatment available at the present time when recurrence develops.

TABLE 1

PULMONARY INDICATIONS FOR LASER

AIRWAY OBSTRUCTION

MALIGNANT

BENIGN

- GRANULOMAS FROM PREVIOUS SURGERY
- TRACHEAL STENOSIS
- TUMORS

It is in this latter area that laser therapy was initially used — in those patients in whom other treatments had failed and the patients were terminally ill with an obstructed airway. This approach has now been expanded and frequently laser therapy is used initially to open an obstructed airway and relieve the acute symptoms. The patient may then receive additional therapy with either radiation, chemotherapy, or perhaps surgery.

The largest experience in the world with these patients is that of Jean Francois DuMon in Marseilles, France, who has treated more than 839 patients with over 1,503 treatments. His results have been very encouraging with the majority of patients able to obtain an airway equal in size to the pre-morbid state. The location of the tumor plays an important role in determining the success of therapy and the more central the lesion, the better the result. This is summarized in Table 2.[1]

TABLE 2 *

RESULTS OF LASER RESECTION

TUMOR SITE	% GOOD RESPONSE
TRACHEAL	95%
RIGHT MAINSTEM	94%
RIGHT UPPER LOBE	48%
BRONCHUS INTERMEDIUS	79%
LEFT MAINSTEM	76%
LEFT UPPER LOBE	44%
LEFT LOWER LOBE	48%

*From DuMon, et al

The long term results are encouraging with the average length of patency approximately four months. There is no limit as to the number of treatments these patients can receive. Laser therapy can easily be combined with radiation or chemotherapy without any complications and should be thought of as an adjunct to other therapies with the role of palliation.

Another area of therapy where laser has demonstrated encouraging applications is in benign lesions. These frequently present as an obstructing tumor, oftentimes in young people with normal lung tissue behind the tumor. The only treatment available at the present time is surgical resection, which is curative but does involve resection of normal lung. Occasionally these are multiple or recurrent lesions, making surgery a nonviable option. Laser offers an excellent alternative to surgical therapy because it does not destroy lung tissue and can be curative and easily repeated.

The final indication for laser therapy is in those patients with tracheal or mainstem stenosis. This problem can arise after prolonged intubation with stenotic fibrosis arising in the area of inflammation around the endotracheal tube cuff. Granulomas can also form at the site of previous airway surgery such as tracheostomy or sleeve resection. The YAG laser has demonstrated good success in treatment of these conditions.

The complications of YAG laser therapy are few and, fortunately, relatively rare. The major risks are hypoxemia, due to the tumor itself or a release of secretions behind the tumor, and hemorrhage, which is defined as a bleed of greater than 250 cc's. Perforation into a major blood vessel with the therapy itself is also a potential problem. In Dr. DuMon's series of 1,503 treatments, there have been seven arrhythmias during anesthesia induction, occurring in patients with severe hypoxemia, and nine cases of massive hemorrhage, all handled medically without long term complications. There have been no perforations.

Our experience at Clarkson to date has consisted of 17 patients treated with 39 applications of the laser. Eleven patients have had excellent results with the complete removal of the tumor and patency demonstrated several months later by repeat bronchoscopy; four patients have had fair results with improvement in aeration and/or control of bleeding; two patients have had a poor result with no improvement at all. We have had no complications.

As in the field of pulmonary medicine, the indications for YAG laser in gastroenterology are also expanding. These are summarized in Table 3.

TABLE 3

INDICATIONS FOR GASTROINTESTINAL LASER

- UGI BLEEDING - ACUTE
- COAGULATION OF POTENTIAL GI BLEEDING LESION
  - A. TELANGIECTASIAS
  - B. ULCER WITH A VISIBLE VESSEL
- RESECTION OF OBSTRUCTING NEOPLASMS

Most upper gastrointestinal bleeding stops spontaneously or can be effectively controlled with medical therapy consisting of a reduction in the gastric acid content, slowing of gastric or portal blood flow, transfusions, and correction of coagulation defects if they are present. However, in approximately five to ten percent of all upper gastrointestinal bleeders, laser photocoagulation may be effective when other measure are not. If the responsible lesion is accessible to the laser fiber, treatment consists of heating the immediately adjacent tissue. This results in localized edema, causing compression of the bleeding vessel and eventually allowing coagulation of the vessel itself directly. Although rebleeding can occur, this time gain allows for stabilization of the patient. Well controlled studies in England have shown a decreased mortality in highly selected populations.[2]

Several investigators have reported favorable results with bleeding and nonbleeding esophageal varices.[3] However, controlled studies comparing medical therapy and invasive therapy, such as endoscopic sclerotherapy or laser therapy, have not been done.

Major potential complications include respiratory depression or distress from overmedication or aspiration, and occasionally, gastric over-distention due to the coaxial gas flow used with the laser fiber. Perforation due to overdistention or excessive use of the laser itself has been reported.

In a similar fashion, the laser has been used to ablate gastrointestinal telangiectasias (Osler-Weber-Rendu Syndrome) and other angiodysplastic lesions of both the upper and lower gastrointestinal tract. Favorable results are demonstrated by improved hemoglobin levels and reduced transfusion requirements. Although periodic retreatment is necessary, overall results suggest this to be the therapy of choice for these specific lesions.

Unquestionably, the greatest use of gastrointestinal lasers is in the palliative and occasional curative therapy of gastrointestinal neoplasms. The largest experience is with esophageal and rectosigmoid tumors.

Cures of esophageal cancer are less than five percent with current medical, surgical, or radiation therapy. These modalities are used generally for palliation. Since the laser can be delivered directly to the tumor site, it will allow a good palliative result in many cases without the complications of surgery. Since the laser effect is localized, it will not interfere with concomitant medical or radiation therapy, if indicated. In addition, laser therapy can rapidly remove tumor bulk and thereby improve dysphagia and restore nutrition quickly. Repeated outpatient treatments may be necessary to maintain a functional esophageal lumen. Therapy is often limited by the linear length of the lesion which would make effective laser therapy difficult. Since the primary goal for treatment in this disease is palliation, the YAG laser should play an important role.

Currently, therapy of patients with obstructing rectosigmoid cancer with widespread metastases has generally been surgical resection with or without permanent colostomy. Laser therapy can be used to open and maintain a functional lumen and thereby avoid surgery in these otherwise terminal patients. In patients who have localized disease but are non-operative candidates due to age or physical impairment, the laser can also be used as a palliative form of therapy. In some selected small cancers, the laser can in fact be curative.

Complications of laser therapy in colorectal disease include local perforation and delayed stenosis in circumferential lesions. The incidence of this, however, is small.

Our experience at Clarkson has consisted of 20 patients. These include seven patients with rectal neoplasms, six with carcinoma of the esophagus or stomach with extension to the esophagus, and seven patients with upper gastrointestinal bleeding. The 20 patients represent 60 treatments using the YAG laser. The results in the rectosigmoid neoplasms have been excellent in all cases. In one case a localized perforation of the cecum occurred from colonic overdistention related to the gas flow. This was treated non-operatively and resolved spontaneously. Excellent local results have also been obtained in treatment of carcinoma of the esophagus, which has allowed us to maintain an esophageal lumen in all cases. Seven patients have been treated with upper gastrointestinal bleeding. Four of these patients responded quite well with no further bleeding and the remaining three patients eventually required operative intervention. One patient developed a pneumoperitoneum following laser therapy, which was most likely related to direct perforation of the stomach. He was treated conservatively.

Summary

YAG laser therapy is a relatively new form of therapy which is safe and easy to perform. In cases of malignancy it is palliative and has been shown to be very effective in rapid relief of major airway obstruction or bowel obstruction. It should, however, be used in conjunction with other forms of therapy. In the area of GI bleeding, the results have not been so encouraging except in cases of arteriovenous malformations. Other endoscopic delivery systems for treating bleeding blood vessels, such as the endoscopic heater probe which will soon be commercially available, will probably replace the laser as primary therapy in this field.

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Factors Affecting the Likelihood that Cardiopulmonary Resuscitation (CPR) will be used by Trained Rescuers

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RAPID initiation of cardiopulmonary resuscitation (CPR) by lay bystanders can decrease mortality and morbidity from out-of-hospital cardiac arrest.[1-7] In 1974, the American Heart Association and the National Academy of Sciences-National Research Council recommended CPR training of the American public starting with school children at the eighth grade level,[8] with priority given to groups with the greatest need such as policemen, firemen, rescue workers, lifeguards, high-risk industry workers, and families of cardiac patients. They also recommended that all physicians, nurses, and allied health professionals be trained in resuscitation.

Since then, chapters of the American Red Cross and affiliates of the American Heart Association have initiated widespread training of lay and professional groups. Over one-third of our 1.2 million Nebraskans have received CPR training, and 98 percent of our secondary schools now offer such training on a voluntary basis. Virtually all rescue personnel and health care professionals caring for critically ill patients now receive such training.

Despite this effort, it is unknown how often a person trained to use CPR will actually use the skill, nor any proof that different subgroups of the lay population are at greater potential of using CPR. We reasoned that if lay subgroups at a high risk of using CPR could be found, training could be targeted resulting in greater benefit with less effort.

We conducted a mail survey of CPR-trained Nebraskans to find the frequency of use of CPR and whether any lay subgroups were more likely to use this skill. We found that health care professionals performed the majority of CPR in our state. We were unable to identify lay subgroups which should receive priority training.

Method

We conducted a mail survey of 934 Nebraskans certified in CPR by the American Heart Association from January 1, 1981 through June 30, 1981. Individuals surveyed were randomly chosen from CPR class rosters. The sample size chosen represented 9.3% (924/10,022) of all Nebraskans certified during this period, 0.91% (934/102,584) of the total number of people ever certified by the Nebraska Chapter of the AHA, and 0.076% (934/1,237,000) of Nebraskans 14 years of age or older in 1981. The survey ran from July 27, 1983 until November 18, 1983, and consisted of four separate mailing. After two mailings, 139 (14.9%) surveys were returned with no forwarding address. These names were replaced by the next name on the original class roster and the new names were used in the last two mailings.

The survey instrument (Figure 1) was designed to determine whether the following variables affected the likelihood that CPR would be used: age, sex, race, education, town size, number of people contacted per day, occupation, place of employment, and living or working with someone who has heart disease. Health care professionals (physicians and dentists, nurses, allied health professionals, EMTs, paramedics) were analyzed separately from lay persons. Each variable was divided into subgroups and crosstabulated with

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FIGURE I

AMERICAN HEART ASSOCIATION
Nebraska Affiliate

Dear Cardiopulmonary Resuscitator:

The Emergency Cardiac Care Committee of the American Heart Association is conducting a survey to determine which factors best predict whether a person will use CPR. You have been selected from a large group of people who were certified in 1981. It is very important that as many surveys as possible are returned. Please return this survey with all questions carefully answered, even if you have not performed CPR since your certification, as soon as possible. Thank you for your cooperation.

1. Age____

2. Sex: M___ F___

3. Race white___ black___ other___

4. Highest Level of Education (6 or less 7 8 9 10 11 12 13 14 15 16 or more)

5. When you were certified in 1981, were you being re-certified?___yes___no

6. Have you been recertified since your certification in 1981?___yes ___no

7. Do you plan on maintaining your certification?____yes ____no

8. Town size that you have lived in longest since certification in 1981.
________(If you live on a farm, use the closest town; if you don't know town size, give town's name.)

9. Average number of people you come in contact with each day?______

10. Occupation (if more than one, check all that apply, but circle the most specific one that you have spent the most time doing since certification in 1981.)

____MD/DDS
____Nurse
____Allied Health Professional
____Paid EMT/Paramedic
____Volunteer EMT/Paramedic
____Homemaker
____Sales
____Professional (lawyer, engineer, minister, etc.)
____Unemployed
____Unsure or other, please specify:____________________
____Law/Fire (Other than paid paramedic)
____Student
____Labor (e.g. farm, construction, factory, craft, transportation, etc)
____Manager/Administrator
____Clerical
____Service (e.g. cook, waiter, cleaner, etc)

11. Place of employment: (if more than one, check the most specific place where you have spent the most time since certification in 1981)

___Emergency Dept./ICU
___Rescue Squad
___Hospital
___Law/Fire Dept.
___Dept. store/restaurant/grocery store
___Transportation. (bus, truck, etc.)
___Unsure or other, please specify: ____________________
___Dr. Office/clinic
___Home/farm
___Factory/industry/construction/warehouse
___Office
___School
___Not Employed

12. Please check one of the following which in your best judgement best describes your job.

___Job with very much general public contact.
___Job with some general public contact.
___Job with very little general public contact.
___Not employed

13. Since your certification in 1981, do you, or have you, lived with someone with known heart disease? ____yes ____no

14. Since your certification in 1981, do you, or have you, worked with someone with known heart disease? ____yes ____no

15. Have you witnessed live CPR since certification in 1981?___yes___no If yes, approximately how many times?____

16. Have you performed live CPR since certification in 1981?___yes___no If yes, approximately how many times?____

17. If you have performed live CPR since certification in 1981, give the most specific place where you last performed CPR?
___a hospital
___a workplace
___a household
___a public gathering (church, sporting event, fair etc)
___a public place (store, street, park,etc)
___unsure or other; please specify:__________

18. If you have performed live CPR since certification in 1981, who was the person you last performed CPR on?
___a patient
___a relative
___a friend
___a stranger
___unsure or other; please specify:__________

AFTER COMPLETION, PLEASE FOLD SO THAT THE AMERICAN HEART ASSOCIATION BUSINESS REPLY ADDRESS WILL BE ON THE OUTSIDE AND YOUR ADDRESS IS ON THE INSIDE, STAPLE AND MAIL.

whether or not CPR had been performed since certification. Chi square test was used to see if any lay subgroup performed CPR significantly more than the remaining lay population. Student's t-test was used to test for a significant difference between continuous variables.

Results:

Of the 934 surveys sent, 845 (90.5%) people trained in CPR were located. 472 (56%) of the people located responded to the survey. Ten (3%) of the 326 lay people and 55 (37.9%) of the 145 health professional people performed CPR at least once since certification (Table 1). The length of time since certification ranged from 25 to 35 months with a mean of 30 months. Thus approximately 1.2 percent of lay rescuers and 15.2 percent of health care professionals performed CPR in a one year period.

Table 1.

Comparison of lay and health care professionals.

	Lay Rescuers	Health Care Professionals	P
Number in group	326	145	-
Age in years	33.3 (14.1)	36.2 (12.9)	< .02
Education	13.0 (1.89)	14.2 (1.74)	< .0001
Townsize (x 1000)	83.0 (121.5)	143.0 (146.6)	< .001
People contacted	74.0 (127.2)	66.8 (126.5)	N.S.
# rescuers who performed CPR	10	55	< .0001
% rescuers who performed CPR	3.1	37.9	-
Arrests witnessed	.076 (.328)	4.2 (10.3)	< .0001
Times CPR performed each rescuer/year	.033 (.197)	2.4 (6.7)	< .0001

Numbers in each row refer to mean; standard deviation is in ( ). People contacted refers to the number of individuals contacted during an average day (rounded to the nearest five). Arrests witnessed are the average number of arrests witnessed since CPR certification. Times CPR performed are the average number of times CPR was done since certification. P refers to the level of statistical significance between values in each category for lay rescuers compared to health care professionals. N.S. indicates that the difference between groups was not statistically significant (P> .05).

Health professionals comprised only 30.7% (145/472) of those surveyed and accounted for 84.6% (55/66) of all persons who had performed CPR. Because many health care professionals performed CPR numerous times in their practice, they accounted for 97.6 percent (408/418) of the number of times CPR was reportedly done. Within the health care professions (Table 2), ambulance rescue squad personnel (EMTs and paramedics) used CPR most frequently (42.1%), followed by nurses (37.2%), allied health professionals (34.3%) and physicians (7.7%).

Table 2: Survey results comparing use of CPR by lay persons and health care professionals.

Variable	Subgroup	Lay persons N	Lay persons %	Health Prof N	Health Prof %
Sex	Male	141	4.3	32	43.8
	Female	185	2.2	113	36.3
Occupation	Physician	-	-	13	7.7
	Nurse	-	-	88	37.2
	Allied Health	-	-	35	34.3
	EMT/Paramedic	-	-	19	42.1
	Homemaker	68	4.4	-	-
	Sales	21	4.8	-	-
	Non-health Prof	21	0	-	-
	Unemployed	9	0	-	-
	Law Enforce/Fire	6	0	-	-
	Student	78	1.3	-	-
	Labor	73	6.8	-	-
	Manager/Admin	28	0	-	-
	Clerical	54	0	-	-
	Service/Cook	38	0	-	-
	Teacher	21	0	-	-
Employment Place	ED/ICU	-	-	12	83.3
	Rescue Squad	-	-	21	66.6
	Hospital	15	0	92	36.3
	Law/Fire	6	0	-	-
	Store	36	0	-	-
	Transportation	10	20.0	-	-
	MD Office	2	0	28	7.1
	Home	101	4.0	-	-
	Factory	50	4.0	-	-
	Office Bldg	62	3.2	-	-
	School	110	0.9	-	-
	Unemployed	8	0	-	-
People Contacted Per Day	5 or less	111	1.8	91	40.7
	10-45	90	3.3	41	34.1
	50-95	60	3.3	10	30.0
	100 or more	65	4.6	3	33.3
Relation to Heart Disease Victim	Live With	30	3.3	7	31.8
	Work With	51	0	41	46.6

N refers to the number of persons in each category. % refers to the percent of persons who used CPR since certification.

The majority (85.5%) of CPR performed by health care professionals was in a hospital setting (Table 3). Public places (such as a store, street, or park) accounted for only 12.7% of all CPR performed. Only 1.8% of health care professionals reported performing CPR at a place of residence. The victim requiring CPR by health care providers 80% of the time was a patient, 10.9% was a friend, 1.8% of the time was a relative, and 3.6% was in an other category. The most frequent place where health care workers perform CPR is in the emergency department or intensive care unit (83.3% of workers in these units had performed CPR), followed by work on a rescue squad (66.6%), and other non-critical care units in a hospital (36.3%).

Compared to health care professionals, lay rescuers were significantly younger, had less education, and lived in towns or cities of smaller population. However, lay rescuers did not come in contact with a significantly different number of people in their average daily lives than health care providers.

Within the lay population the typical certified rescuer was relatively young (33.3 yrs) and well educated (48% had completed at least high school). None of the following variables significantly influenced the likelihood that CPR was performed: age, sex, race, education, town size, number of people contacted per day, amount of general public contact per day, or whether or not the rescuer worked or lived with someone with known heart disease. The only subgroups of the lay population that performed CPR more often than others were laborers and transportation workers. In contrast to health care providers, lay rescuers performed CPR in a public place 70 percent of the time. Victims receiving CPR were a mixture of friends, relatives, and strangers.

Table 3: Survey results comparing use of CPR by lay persons and health care professionals.

Variable	Subgroup	Lay persons N	%	Health Prof N	%
Victim Receiving CPR	Patient	0	0	44	83.0
	Relative	1	10	1	1.9
	Friend	2	20	6	11.3
	Stranger	1	10	0	0
	Other	6	60	2	3.8
Where CPR Done	Hospital	1	10	47	85.5
	Work	1	10	0	0
	House	1	10	1	1.8
	Public Place	7	70	7	12.7

N refers to number of cases where CPR performed.
% refers to the percent of total number of cases where CPR performed.

Discussion:

We found a marked difference in the frequency of use of CPR in health care professionals compared to lay persons. Health professionals in our survey were thirteen times more likely to use CPR than trained lay rescuers. All but 2.4 percent of the CPR performed by the entire surveyed population was done by health care professionals. These findings underscore the need to train and maintain CPR skills for all health care professionals.

Most health care providers performed CPR in a hospital setting. As predicted by the American Heart Association,[8] workers in hospital critical care units (emergency departments and intensive care units) and rescue squad personnel used CPR most frequently. Nurses and allied health personnel (e.g., respiratory therapists and physician's assistants) performed CPR much more frequently than physicians. A likely explanation is that physicians delegate the responsibility for performing CPR to nurses and other health care providers in a hospital setting.

The 1.2 percent chance that a lay rescuer will use CPR in a year is likely an overestimate of the risk for each citizen. Individuals who take CPR training may do so because of occupation or perceived need to use the technique on a friend or relative, either of which might increase their risk of actually using the skill. On the other hand, it is possible that some of our lay (or even health care professionals) may have had occasion to perform CPR and did not. Factors[9] which have been found to influence whether a bystander to an emergency will assist include how sure the bystander feels about his ability to help,[10] the bystander's perception of whether or not others present are able to help,[11] whether the victim is known to the bystander, the bystander's interpretation of the problem (is the person really in trouble or just under the influence of alcohol or drugs), and whether distasteful physical contact will be required, as in doing CPR on a person who has vomited. We presume failure to act despite training was uncommon since most individuals who take CPR training appear highly motivated to use the skills they are taught.

Kivela[12] has reported that approximately three percent of lay citizens in Finland (both trained and untrained) sometime during their life had given closed-chest massage to patients in cardiac arrest. In King County, Washington[13] there were 435 out-of-hospital cardiac arrests in 1979, 23 percent of which had CPR initiated by a lay bystander. In that year, there were an estimated 232,000 King County residents trained in CPR. Thus, in the general population the chance of an individual citizen performing

CPR may actually be as low as one chance in 2000 (0.05 percent per year).

None of the subgroups that seemed intuitively at greater risk (e.g., more than 100 people contacted per day, working or living with someone who has known heart disease) performed CPR more frequently than the total group. A higher percentage of laborers and transportation workers performed CPR than other lay groups. The explanation for and significance of this finding is uncertain, and could just be an unusual statistical quirk.

Our finding that the majority of lay CPR was performed in a public place contrasts with the Seattle experience. In that city, Bergner[13] found that over three fourths of all out-of-hospital cardiac arrests occurred in the home, while only 15 percent occurred at work or in a public place. Yet citizen-initiated CPR was much more frequent outside (54%) than inside (32%) the home.

A significant limitation of our study bears mention. Layperson CPR was a rare event in our survey population, with only ten instances recorded in the entire sample. It is possible there is a slight difference in risk among such subgroups which went undetected by our study because the sample size was too small. Even though a statistically significant difference could not be shown, there was a trend in the lay group for more CPR to be done by rescuers coming in contact with greater numbers of people per day. A further study interviewing just lay rescuers who have actually performed CPR might clarify whether population density is significant enough to warrant targeted training.

In conclusion, since health care professionals perform the vast majority of CPR in our state, we should continue to concentrate training and recertification on such individuals. Although the chance that an individual trained lay rescuer will actually use CPR is small, the finding in Seattle and elsewhere[1-7] that mass training can reduce mortality and morbidity from out-of-hospital cardiac arrest suggests we should continue our training of lay citizens. Our study does not exclude the possibility that subgroups exist which should be targeted for CPR training. Such groups may be found by further studies of lay rescuers who have performed CPR.

Summary

The American Heart Association (AHA) and American Red Cross have recommended training large segments of the lay population to perform cardiopulmonary resuscitation (CPR). To determine how often trained lay and health care rescuers actually perform CPR, we performed a mail survey of 934 randomly selected Nebraskans trained within the last three years. 473 (56%) completed the survey. Health care professionals comprised 30.7% of those surveyed yet accounted for 84.6% of all persons who had performed CPR and 97.6% of the number of times CPR was reportedly done. Rescue squad personnel performed CPR most frequently (42.1%) followed by nurses (37.2%), allied health professionals (34.3%) and physicians (7.7%). Lay rescuers performed CPR 13 times less frequently than health professionals. Although health workers usually perform CPR in hospitals, lay rescuers primarily perform CPR in public places. None of the following factors significantly influenced the likelihood that CPR was performed by lay rescuers: age, sex, race, education, town size, number of people contacted per day, living or working with someone known to have heart disease. We conclude that an individual lay rescuer has less than a 1% chance per year of having to perform CPR. Although our study does not exclude the possibility that subgroups exist which should be targeted for CPR training, the infrequent, random occurrence and distribution of cardiac arrests in a community require blanket training of a large population base for optimal lowering of mortality and morbidity.

Acknowledgement:

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Early Detection of the Hearing Impaired Newborn: The High Risk Registry

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SPEECH and language acquisition begins at birth and significant receptive language develops by one year of age.[1] Approximately 80 percent of language growth is achieved by age three.[1] Early detection of hearing impairment for medical management and educational intervention is therefore essential for the development of communication skills.

Incidence

The consensus is that hearing impairment occurs in 1:300 to 1:400 of all children.[2] In normal newborns the apparent incidence is 1:1000.[3] Admission to neonatal I.C.U. increases the likelihood to 1:50.[4]

Diagnostic Delay

Average age at detection is between 2.2 and 2.9 years for severe hearing impairment and 4.5 years for moderate loss.[1]

The commonest causes of diagnostic delay are:

1) Failure to listen to the parents' observations
2) Lack of screening for hearing and speech problems
3) Reluctance to arrange prompt referral for audiologic assessment.[5]

Procrastination by the physician continually stands out as a cause of long delays, possibly because of beliefs that proper hearing tests must wait "until the child is old enough."[1]

Hearing loss is often not discovered until serious language, reading, learning and emotional problems have already occurred. The longer a deficit is unidentified and untreated, the more difficult these adverse effects are to overcome.

Waiting to demonstrate developmental failure to diagnose hearing impairment is not only inefficient, but risks severe limitation of

Reprint requests to: Donald T. Glow, M.D., Childrens Memorial Hospital, 8301 Dodge Street, Omaha, Nebraska 68114 development. Because such delays are unacceptable, a comprehensive, easily implemented model for the earliest possible diagnosis and treatment of hearing impairment is needed. However, an extensive literature survey on implementing early identification programs shows no clearly defined policy.[6]

Early Screening

Organizing a program to detect early hearing loss leads to a search for the earliest appropriate time and place for implementation. Any program should be universally applicable, serving infants from cities of under 25,000 (which contain 55% of the U.S. population), as well as those in large urban centers.[6] Accessibility in the newborn nursery makes this a realistic and practical place to identify infants at risk for hearing loss. The high risk registry is generally considered the most efficient method of screening large numbers of newborns for potential hearing handicaps and it is also the most widely used method today.[7]

High Risk Registry

In 1973, the Joint Committee on Infant Hearing Screening* recommended identifying infants at risk for hearing impairment and the establishment of a high risk registry. Following the lead of Utah and Colorado, where such statewide registries are now well established,[8] Childrens Memorial Hospital in Omaha began a metropolitan registry in 1980 involving the following hospitals: Archbishop Bergan Mercy, Bishop Clarkson Memorial, Immanuel Medical Center, Nebraska Methodist, and Midlands Community Hospital. In 1982, the Committee expanded the risk criteria, and our high risk registry modified these to obtain the following questionnaire:

1. Has anyone on either side of the baby's family been born deaf or attended a school for the deaf?
2. Do you or your doctor have any reason to believe you could have had measles during your pregnancy?
3. Do you feel you have any specific reason to be concerned about your baby's hearing?
4. Birthweight less than 1500 grams?
5. Bilirubin level greater than 15 mg/100 ml serum?
6. Anomalies of the ear, nose or throat?
7. Apgar score of less than 4?
8. Anoxia?
9. Illness (Sepsis, Meningitis, treatment with antibiotics, etc.)?

The high risk registry form is completed in the newborn nursery by hospital personnel. Any positive response indicates that the infant is at risk for hearing loss and the attending physician is so notified.

Methods of Hearing Assessment

Optimally, there is an initial screening, including observation of behavior or electrophysiologic response to sound while still in the newborn nursery. At that age only a severe to profound hearing loss can be determined with this technique. If the infant passes, further behavior audiometric testing is recommended at age 6 months to rule out mild to moderate hearing loss. If the infant fails, behavioral audiometric testing as a newborn or at age 6 months, Brainstem Electric Response Audiometric (BERA) is recommended. BERA testing is an objective method of testing that can document hearing threshold at any age as it requires no cooperation.

Results

During the four year period from 1980 through 1983, a total of 28,400 newborns were screened using the above criteria. 1,837, or 6.5% were identified at risk for possible hearing impairment. This compares favorably to the national average of 7%.[9] It was found that 28 infants had hearing impairment and recommendations were made for evaluation, treatment and follow-up.

Comments

Despite proven success, health care providers have not been convinced of the cost effectiveness of early hearing impairment detection programs.[6] We have demonstrated that this can be done in Nebraska reasonably and effectively.

Use of the Omaha model could be easily and inexpensively extended through the inclusion of pertinent questions on the birth certificate. This is possible as long as the revision is approved by the National Center of Health Statistics. The obvious major advantage is the near 100% screening rate afforded since the birth certificate is a mandatory legal instrument.[7] This should identify between 25 and 30 hearing impaired infants in the state of Nebraska annually, most of whom would not be detected until later in life. The advantages to these children and their families are obvious.

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*The Joint Committee consisted of representatives from the American Academy of Pediatrics, Academy of Otolaryngology-Head and Neck Surgery, American Nurses Association, and American Speech-Language-Hearing Association.

Summary

The importance of early detection of the hearing impaired newborn and the consequences of late diagnosis are discussed. A high risk registry was established in Omaha in 1980. Out of 28,400 newborns over the past 4 years, 1,837 or 6.5% were identified at risk. It is recommended that a statewide program be implemented so all Nebraska newborns may have the advantage of this screening program.

Acknowledgement

This program has been supported in part by a grant from the Nebraska State Department of Education.

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President's Page

"MEDICINE IN TRANSITION"

Herbert E. Reese, M.D.

CONCERNED INDIVIDUALIZED CARE: THE COMMONALITY OF OUR PROFESSION

The theme proposed for this year was "Medicine in Transition" as one could foresee on the horizon the remarkable changes in the financing and the delivery of health care. Unforeseen was the rapidity of this change; the theme would probably have been better titled "The Transformation of Medicine". Over the past year, we have seen corporate medicine move into Nebraska. Hospital Corporation of America manages two of our institutions; AMI owns and manages one of our large teaching institutions; Health America has two closed panel HMO's in two of our urban centers; Share has an open panel HMO in one of our teaching institutions, and Humana is seeking a certificate of need for an HMO. There has been institutional or physician entrepreneurial development of IPA's and PPO's. Blue Cross/ Blue Shield is in the developmental stages of an open panel HMO. Hospital medical staff joint ventures are being developed, and satellites, free-standing clinics, Urgi-centers, convenience centers, and surgi-centers, as well as physician practice networking, have appeared. We are seeing advertising and marketing we wouldn't have dreamed of a year ago. In this procompetitive market, people have positioned themselves to retain or enlarge their "share of the pie" in this health care marketplace. Physicians are caught in a multibillion dollar industry as a minority group making us less than 4% of those who make their livelihood in the health care fields. The rapidity of these changes so foreign to the traditional delivery of medical care has left the physician just short of panic. As one physician expressed, "What the hell is happening?" There is no question that change is here, and in Nebraska, change is going to rapidly progress under the present system. We are making up for social mistakes in the 60's and 70's where we developed an egalitarian delivery system without provider or budgetary controls. Throughout the year, I have discussed in these presidential pages the changes in the financing and the delivery of medical care and the involvement of the players. One of the greatest fears is the rapid development of corporate structure in the practice of medicine. In order for corporations to be effective in the marketplace, they have to harness physicians to corporate goals, thus creating internal discipline and compliance. No wonder physicians are uneasy!

The Nebraska Medical Association has made every effort to meet the challenges of the transition. Early in the year, a long-range planning committee was convened to discuss the multiple ramifications of change in the financing and the delivery of medical care and to redefine association goals in this changing environment. The many pressing considerations were given to the Board, commissions, committees, counselors and special task forces for review, development, and action. These reports were presented to the Interim Meeting of the House of Delegates and the Annual Meeting of the House of Delegates. Four precise goals have been defined to meet the challenges ahead. These are the goals:

1) Representation of the medical profession

The Nebraska Medical Association's most important purpose is to serve as the vehicle for the representation of the medical profession on a local, state, and national level. Physicians have a moral responsibility to advocate in the best interest of their patients. Their professional organizations have a similar duty to meet that responsibility in a truly concerted manner. This representation must be consistent with the additional responsibility to act in the best interest of the public.

2) Provision of information

With the rapid changes, the association must provide reliable information to matters concerning the profession both scientific and socio-economic. With the expanded economic forces, socio-economic information to the physician and to the public will be necessary.

3) Establishment and maintenance of standards of conduct and performance

The growing diversification in health care delivery will intensify the pressures on all physicians to uphold the highest standards of professional conduct while administrating quality care in a cost effective manner. The Nebraska Medical Association, using national guidelines and with local variations, must provide guidelines for physicians in the professional conduct and performance of their practice.

4) Membership and membership benefits

The purposes of all medical societies are in some way related to enabling physicians to provide quality care to their patients. With medicine's changing environment, adequate representation, information and standards can only be developed with active membership. Never before has membership been so important, individually and collectively. In order for medicine to be recognized as a profession with standards, broad membership is necessary. In order to accomplish medicine's goals, active membership locally and nationally must be sought. Benefits must be attractive and reasonable for the membership.

These four primary goals were developed along with high priority items to meet the future challenges. The entire report will be carried in this journal with the proceedings of the House of Delegates. Along with the task of meeting with new challenges, the association was overseeing the development of an operational peer review organization. This has been developed on an educational, advocacy basis. I think we can be proud of this organization, as it is the best that can be done under the law and is not adversatively based as are some PRO's. We've also had a very productive legislative session. The Nebraska Medical Association has been instrumental through LB407 in the development of technical reviews of health care licensees through the Health Department prior to any legislative considerations. The Association has been active in membership recruitment as well as development and expansion of membership benefits.

All these complex tasks required a remarkable amount of time. I am sure the membership joins me in a very hearty thanks to the Board, counselors, committees, commissions, task forces, along with their supportive wives. I would especially like to commend the staff for its time and efforts. When physician members involvement doubles, the staff quadruples. All tasks were accomplished promptly and so a special thanks to Ken Neff, Bill Schellpeper, and their staff, Mary, Bobbie, Janet, and Nancy. I can tell you members we may not have the quantity, but we have the quality!

Since this is my last presidential page, I would like to take a little editorial license and comment on the concerns and opportunities of the future. As I have alluded through these presidential pages this year, corporate medicine is one of our major concerns. Physician discipline and control will have to be bound to corporate goals. The physician sees loss of control. He sees commodity versus a need, big versus small, economics versus care, corporate employed versus individual contractor, a medical technician versus a medical professional, and an allocator versus an advocator. The advocator is one who works with concern, compassion, and intellectual completeness. The allocator is one who is mechanical, unconcerned, and functions by protocol. Are we going to have two types of physicians? A medical professional with an ethical bond and advocacy and also a medical technican without an ethical bond and an allocator. And will the patient get to select which physician he wants to care for him or her?

Corporate medicine has brought all this bigness into Nebraska medicine this year and it is very interesting and sometimes exciting, yet medicine's encounters have not changed;

they are still on a one-on-one basis. The physician's common bond is the patient; this is our commonality as a profession. We are the advocate of the patient. We are to serve the concerns and the needs of that individual patient to the best of our ability. This responsibility can't be abdicated. This duty is part of our oath that has stood for hundreds of years. Our services, based solely on the concerns and needs of individual patients, are provided with privacy and confidentiality. High-tech, yes, but also high-touch and human. As economics become a consideration of the individual patient's needs, other determinants of need will soon follow. Age, ability to pay, worth to society, and others will become determinants, all without any relevance to the clinical situation. To this we have to object. Our pricing mechanisms or delivery systems must not interfere with what our profession has always stood for all these years. We can't object to change, and will be a part of this change, but we will have to enlighten some of these delivery systems for we must not compromise our code of ethics. We need to work with these systems to enrich these standards. Our common professional bond is the standard for the future.

In summary, your Association has made great effort this year to meet the challenges of the transition. This effort will be necessary in succeeding years as physicians must take an active role in the changes. We are seeing megatrends, but we are left with mini encounters. Our business is still a one-on-one encounter. Our bond is to the individual patient; that is our commonality, our professionalism, that sets us apart whether we are "fee for service", a contractor, or employed in a multi-variety of delivery systems. Our only determinant is the medical needs of that individual patient. Our professionalism allows for no other determinants of individual patients needs. This concerned care for the individual is our common bond, and it deserves that term, physician healer, the basis of our profession.

It indeed has been a great pleasure to be your President the last year, and I hope I have made a small contribution to our great profession and association. Good luck to you over the next year, Dr. Frank Donahue. You will make a great President for the Association.

The Auxiliary

At the annual meeting of the Nebraska Medical Association Auxiliary the following received awards: Woman of the Year, Helen Mahon from Norfolk and Merit Award, Jane Taylor of North Platte.

Helen Mahon

As Woman of the Year Helen Mahon has been very active with the American Cancer Society receiving the Honorary Life Time Director of the American Cancer Society Nebraska Division. Only 4 Nebraskans have ever received this award and Helen the only woman. She also received the Annual National American Cancer Society Divisional Award 1981 Volunteer Award. She brings cancer patients from Norfolk to Omaha for treatments, helps with acquiring special equipment they need and generally a special friend to these people. Helen is a person that touches everyone she comes in contact with in a very positive and spiritual way. She has been very active in the Northeast Quad Medical Auxiliary for several years.

Her hobbies include golf, bridge, gardening and birdwatching. "A definite Woman of this generation, 80 years, current in Life."

Jane Taylor has been awarded the Merit Award for all of her many activities in Lincoln County Medical Auxiliary as well in North Platte.

Jane was instrumental in organizing the GEMS program and has worked with the Organ Donor Program in the Auxiliary.

Jane and her husband Bernie have been generous in sending students to nurse's training and to LPN school.

Some of her community activities include an active volunteer at Great Plains Regional Medical Center Hospital, a member of the Compassionate Friends Board, American Cancer Society, Community Playhouse and Town Hall, and served on Sen. James Pappas 1983 campaign. She received the Waken Award for Campfire leaders.

She is the mother of three children, Deb, Mike and Mark. She enjoys cooking, gardening, tennis and fishing.

Congratulations to both of these very deserving women.

Bev Kruger

Coming Meetings

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

TETON'S GENERAL PEDIATRIC CONFERENCE — June 30 - July 6, 1985. Sponsor: Department of Pediatrics, University of Nebraska College of Medicine. Location: Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 20 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Pediatric cardiology, gasteronterology, genetics, asthma, allergies and immunology, neonatology, nutrition and eating disorders. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

TETON'S SPORTS MEDICINE CONFERENCE — July 7-11, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: Conference Center, Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 16 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Current concepts on evaluation, conditioning, management and rehabilitation of the recreational and competitive athlete as well as use of exercise therapy in a variety of medical problems and injuries. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

LAKE OKOBOJI SPORTS MEDICINE CONFERENCE, "THE YOUNG ATHLETE" — July 24-27, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: The New Inn Conference Center, The New Inn Lodge, Okoboji, Iowa. Credit: 12½ Hours AMA Category I and AAFP Prescribed. Fee: $150 physicians, $75 residents in training & students. Topics: Identification and management of sports related injuries, current concepts on nutrition and the care of the young athlete with medical problems. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, Nebraska 68105. (402) 559-4152.

EMERGENCY MEDICINE REVIEW — September 23-28, 1985 and will be repeated on October 1-12, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. Credit: 45 hours AMA Category I, AAFP Prescribed & ACEP Category I. Fee: $425 physicians, $325 residents in training. Content: This course will provide physicians engaged in the evaluation and treatment of urgent and life threatening conditions with an in-depth review of emergency medicine. Special attention will be given to the recognition of conditions that must be identified immediately, and evaluation of nonemergency conditions. Daily national board type exams will be given. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF KANSAS

WHAT'S NEW IN DIABETES? — May 1, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: AMA 7.5 hrs. Cat. I, AAFP 7.5 hrs., CNE 8 hrs., Dietitian 8 hrs., SW 8 hrs.

DIABETES FOR PHYSICIANS — May 2, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Missouri. Credit: AMA 4 hrs., AAFP 4 hrs. Fees: $10 (includes lunch).

ADVANCED CARDIAC LIFE SUPPORT — March 20-21, 1985, May 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Building, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas. Fee: $150 physicians, $75 nurses, EMTs. Credit: 13.5 hrs. AMA Cat. I, 13.5 hrs. AAFP, American Heart Association Certification.

TECHNOLOGICAL ADVANCES IN RESPIRATORY CARE — May 9-10, 1985. Sponsor: University of Kansas Medical Center. Location: Hilton Plaza Inn, 45th and Main, Kansas City, Missouri. Credit: 11 hrs. AMA, AAFP, CNE, RT, CRNA.

KANSAS MEDICINE: TEN YEARS LATER — May 17, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 6 hrs AMA, AAFP.

ADVANCED CARDIAC LIFE SUPPORT — May 21-22, 1985. Sponsor: University of Kansas Medical Center. Location: Student Center/Continuation Study Bldg., University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA, 13.5 hrs. AAFP. Fees: $150 physicians, $75 nurses, EMTs.

THE CHILD WITH CHRONIC DISEASE — May 23-24, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA, AAFP, CNE.

ADVANCED TRAUMA LIFE SUPPORT — May 30-31, 1985. Sponsor: University of Kansas Medical Center. Location: Orr-Major Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 16 hrs. AMA, 15 hrs. AAFP, 15 hrs. AOA. Fees: $375. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-6124.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — June 13-14, 1985. University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA. Fees: $625.

SCHEDULED MEETINGS

ALASKA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION — June 5-8, 1985 in Haines, Alaska. Registration should be sent in care of: Alaska State Medical Association, 4107 Laurel Street, Suite 1, Anchorage, Alaska 99508, (907) 562-2662.

Welcome New Members

Martin Tilley, M.D.
1317 - 2nd Ave
Kearney, NE 68847

Kevin M. Cawley, M.D.
8303 Dodge St.
Omaha, NE 68114

Trent W. Quinlan, M.D.
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Karen J. Phillips, M.D.
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Rex K. Reckeway, M.D.
2300 South 16th
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Hastings, NE 68901

WashingtoNotes

(Continued from page 12A)

the patient's condition; comparing the medical condition and treatment of patients in physicians offices with those in hospital outpatient or ambulatory settings; examining the effect of hospital DRGs on skilled nursing facilities, home health agencies, rehabilitation facilities, and swing bed services; expanding private risk-sharing for long-term care costs; promoting home care by the family or other community arrangements; designing a new payment for end-stage renal disease patients; and improving the formula used to compute prospective payments to Medicare HMOs.

* * *

Some Preliminary Results Reported

If federal policymakers want to pay physicians by diagnosis, they should start with surgery and make payments to hospital medical staffs rather than to individual physicians, a Massachusetts research firm advised Medicare officials in February.

The advantage of this approach, according to the Center for Health Economic Research, is that it would discourage a growth in physician services said to be responsible for about 40% of recent increases in Medicare Part B expenditures for medical services. Half of all Medicare physician payments — but only a fourth of hospital admissions — would be affected.

Based on 900,000 1982 Medicare claims in Michigan, New Jersey, North Carolina, and Washington, the CHER study is the most extensive look yet at how Medicare's diagnosis-related groups (DRGs) hospital pricing system could be extended to physicians. As such, it is expected to be a critical element in a Health Care Financing Administration report to Congress on the "advisability and feasibility" of physician DRGs.

The CHER study is, however, only a part of a body of HCFA-funded research just coming into final form as the agency rushes to meet July's deadline for the report which originally was not due until December. Reported at a conference sponsored by HCFA and Project HOPE, the CHER work is one of a number of studies that raise concerns about physician DRGs.

Two Boston University MDs concluded, for example, that even if refined, DRGs aren't likely to accurately reflect the costs of a particular case. A Virginia firm found that a physician DRG was "at best not unthinkable." And a Project HOPE study warns that adoption of physician DRGs might permanently sidetrack efforts to encourage the growth of HMOs and other capitation plans.

Physician reactors disputed the assumption that physician DRGs will curtail an increasing volume of services and questioned the wisdom of any plan that asks physicians to move from the role of patient advocate to businessman. Several speakers suggested that hospital medical staffs are not well-enough organized to receive and redistribute the DRG payment.

* * *

Durenberger Calls for Medicare Incentives for Nonsmokers

Now shed of the pipe that had become his hallmark, Minnesota Republican Senator David Durenberger wants Medicare beneficiaries to follow his example.

To encourage them, the Senator is proposing that elderly smokers pay higher Medicare premiums than nonsmokers. Such a policy, he argued, would follow private insurers "lead in rewarding those who choose to avoid smoking which unquestionably increases the risk of illness." It could also make a "positive contribution" to "seniors' health" and to the "health bill of the nation."

Called the Medicare Cost Incentives for Non-Smokers (S-357), the bill is part of a package of three measures that Durenberger introduced to "explore the many ways Medicare can be restructured to incorporate the possibilities of prevention." A second bill would raise the Medicare Part B deductible and then permit certain preventive health services to count toward the deductible. The third would fund five Medicare demonstrations to test Medicare coverage of preventive services.

* * *

Medic Alert Plans Major Expansion

The Medic Alert system, whose members wear metal bracelets to signal potentially hazardous medical conditions, intends in the next two years to develop a medical abstract that could be the basis for a worldwide computerized medical records system.

The two-million member foundation will work with the Defense Department and with medical specialty groups in an effort funded through a $140,000 grant from the Robert Wood Johnson Foundation.

Medic Alert officials, who outlined their plan at a Washington press conference, say their primary interest is to improve and expand their own emergency warning system but they believe that a highly mobile population has created new demands that go far beyond the original Medic Alert concept. They suggest that the AMA/GTE Medical Information Network would be an ideal network for their proposed system but they add that the abstract they are developing will be part of the public domain — available to a wide range of organizations that have an interest in their plan.

* * *

National Academy Reports on American's Low Birthweights

Health professionals and policymakers must intervene more vigorously to reduce the incidence of low birthweight infants, according to a new National Academy of Sciences (NAS) report.

In the United States, low birthweight babies represent 6.8% of all live births, an incidence that is higher than at least 12 other developed countries. Low birthweight babies are almost 40 times more likely to die in the first months after birth and are much more likely to suffer from serious diseases or congenital conditions.

Although the proportion of moderately low birthweight infants appears to be declining, there has been no decrease in the proportion of infants with very low birthweights, NAS found. Between 1971 and 1981, the percenage of infants weighing 1500-2500 grams fell from 6.50% and 5.64%, but the percentage of infants weighing less than 1500 grams increased from 1.14% to 1.16%.

"To reduce the incidence of this major cause of infant mortality, we must treat prevention of low birthweight with the same commitment that we devote to the immunizaton of children against polio or other major diseases," said Richard E. Behrman, M.D., chairman of the NAS committee.

Added Gordon Avery, M.D., chairman of the Department of Neonatology at Washington's Children's Hospital National Medical Center: "It is not biologically necessary to have this much prematurity. We need to start doing for poor folks what we already do for ourselves." Prevention of prematurity is much more efficient than caring for premature infants, he noted.

Moreover, improved prenatal care is cost-effective, NAS found: for a high-risk population of 1.4 million women, each dollar spent on prenatal care can save as much as $3.38 on specialized care for low-birthweight infants.

The NAS report recommended several steps to reduce the incidence of low birthweight infants:

* improving access to care. State Medicaid programs should attempt to enroll more eligible women, offer earlier and more regular high-quality care, and reimburse for a larger number of prenatal visits. Medicaid also should encourage greater participation by obstetricians and gynecologists.

* changing the focus of prenatal care toward care that can be provided in the first and second trimesters of pregnancy.

* improve education about smoking and nutrition, provide for greater accessibility, using telephone consultation, counseling, emotional support and acceptance, and understanding of language and cultural barriers.

* improving outreach. Messages could stress the problems of low birthweight babies, the benefits of pregnancy planning, the risks of smoking and drinking in pregnancy, the importance of good nutritional practices. Television, newspapers and magazines could publicize these messages; school programs would

be another natural setting for communicating information to young people.

* * *

NIH Consensus on Travelers' Diarrhea

Rapid institution of treatment can shorten travelers' diarrhea from three to five days to 30 hours or less in most people, according to a National Institutes of Health (NIH) panel of experts.

Travel to high-risk areas of Latin America, Africa, the Middle East, and Asia is associated with 20% to 50% of diarrhea in travelers from more developed countries. Careful dietary and hygenic practices will prevent some, but not all, cases.

Before leaving the US the travelers should obtain two types of drugs: an anti-motility agent and an antimicrobial agent. By obtaining them in advance, the traveler can avoid buying potentially dangerous over-the-counter products and can begin prompt treatment if needed.

For mild diarrhea, the traveler should take an anti-motility agent. Drugs such as diphenoxylate or loperamide were recommended by the NIH panel. Bismuth subsalicylate, which works somewhat slower but is also effective, may also be used. The products come in convenient dosage forms and provide prompt, although temporary, symptomatic relief.

For more serious cases, an antimicrobial drug should be used. These cases — manifested by three or more loose stools in an 8-hour period, often accompanied with nausea, vomiting, abdominal cramps, fever, or blood in the stools — can be shortened to 1 or 1½ days with this type of drug. The NIH panel recommended combining 160 mg trimethoprim and 800 mg sulfamethoxaxole or taking 200 mg trimethoprim alone, twice daily.

* * *

PDQ System Unveiled

At a press conference in February, the National Cancer Institute unveiled "The Physician Data Query," a computer system to provide up-to-date cancer information to physicians across the country.

Any physician with a computer terminal, a keyboard and a telephone hookup can gain access — for a $50 one-time charge and a $15 additional monthly fee — to the central PDQ computer. The average inquiry will probably cost about $5 or $10, based on the system's $20 average hourly rate.

The user is offered a series of choices: news, cancer information, physician name, and research protocols either a brief summary or a more detailed description of state-of-the-art treatments for 82 major cancers. It also lists 2,000 institutions which have organized programs for cancer patients as well as the estimated 1,000 active treatment studies now underway around the country. If no standard treatment existed, the PDQ user would be referred to ongoing clinical trials.

Many medical groups,including the AMA, fear that the computer's list of physicians will be elevated to "special expert" status simply because of their inclusion in the PDQ system. As a result, some physicians may feel constrained to refer their patients only to persons on the list; similarly, patients who might see the list might question their physician's competence if he has been omitted from the list. General practitioners who provide state-of-the-art treatment are omitted; conversely, some oncologists on the list may not provide the best or newest form of treatment, they note.

NCI concedes that the list is as comprehensive as possible, but not perfect. Simply because a physician's name is on the list does not imply special expertise or NCI endorsement; alternatively, many family practitioners not included in the list may be excellent caretakers of cancer patients, according to NCI. "But the only alternative," said NCI Director Vincent DeVita, Jr., M.D., " was to have no list at all."

The system also has been criticized for preempting journal articles, and thus bypassing the important peer-to-review process to which descriptions of new cancer therapies are subjected.

NCI says that because PDQ contains descriptions of the theories — and preliminary results — of unpublished treatment techniques now under investigation, it can keep doctors better informed. "We may be ahead of the conclusions that a physician would draw upon, based solely on reading of journals," said Dr. DeVita.

An editorial board of 21 physicians meets monthly to review and discuss new treatment and investigational advances, as well as cancer treatments already published in the literature. A board of 51 cancer specialists aids the physician-editors in identifying and reviewing new developments in treatment of the disease.

The AMA has agreed to help NCI evaluate the system.

* * *

Medicare Surveys Charge Quality DRG Problems

Reports that elderly Medicare beneficiaries are being discharged from hospitals "quicker and sicker" since the advent of Medicare's new prospective pricing system are gaining attention in Congress.

Although evidence to date is largely anecdotal, two recent surveys for Congressional Committees on Aging indicate a trend in which elderly patients who still require some type of care are released from hospitals only to discover that alternative services such as nursing homes do not exist in their communities. The concern is particularly acute in rural areas and it is heightened by Reagan Administration proposals to freeze Medicare payments to hospitals.

The two studies for Congress buttress an earlier American Medical Association survey which found that a majority of physicians believe quality is or will be lower under the prospective diagnosis related groups (DRG) system than in the past. Performed by the General Accounting Office and the House Aging Committee's Task Force on the Rural Elderly, both concluded that patients leaving the hospital since the advent of DRGs are sicker than was the case prior to DRGs.

The General Accounting Office study was done at the request of the Senate Aging Committee, whose chairman Sen. John Heinz, R-PA, said the study shows that hospitals are discharging patients "quicker and sicker." In many cases, he added, the patients are going home to a "no-care zone" where alternative levels of care are not available.

The GAO study of six communities (Pittsburgh, Orlando, Richmond, Seattle, Corpus Christi, and Adrian, Michigan) also concluded that nursing homes and home health agencies may deny care to "heavy care" and Medicaid-eligible patients; that many are not properly equipped to take care of the sicker patients they are seeing today; and that shifting care of relatively ill patients outside the hospital will undoubtedly cost beneficiaries more out of pocket and could increase overall costs as well.

The GAO also found that many beneficiaries are "upset and confused" about their Medicare coverage because they have been told improperly that they must leave the hospital because their Medicare coverage has been exhausted.

The GAO findings were repeated in the House Committee Task Force's survey of state nursing home ombudsmen. Some 77% of respondents said patients are being discharged "sicker or much sicker" than before DRGs. Over half said skilled nursing care is not adequate to meet the needs of discharged patients in rural areas and one-third said this care was inadequate in urban areas.

The surveys prompted hearings in the House Aging Committee, whose chairman Rep. Edward Roybal (D-CA) said at the first of a planned series of DRG hearings that his two major concerns center on the impact of DRGs in rural areas and fears that Peer Review Organizations "are spending most of their limited resources on reducing costs — not assuring health care quality."

Although Health Care Financing Administration officials contended that DRGs may "actually enhance" quality of care, a variety of witnesses for hospitals, physicians and the elderly agreed that rural and inner-city hospitals are already having financial problems that are bound to grow into real quality shortcuts if the Reagan Administration's proposed freeze on hospital and physician payments is enacted.

Dr. James E. Davis, who is Speaker of the AMA House of Delegates, told Roybal that a freeze that leaves out defense programs and singles out payments to physicians and hospitals "is unconscionable." The North Carolina surgeon said "there is an atmosphere of constant change and lack of stability" in the

Medicare program and he urged that Congress not extend the system to physicians and other providers before it has examined the results on hospitals and looked at several studies that have not yet been completed.

Both Dr. Davis and Louis Krieger of the American Association of Retired Persons opposed the Reagan Administration's proposal to continue the current freeze on Medicare physician fees for another year. Dr. Davis said a continuation of the freeze could discourage physicians from treating Medicare beneficiaries and would make "physician reimbursement under Medicare the only area under the budget proposals that would be frozen for two years."

* * *

PROPAC Recommendations

Medicare rates in fiscal 1986 would rise by an estimated 1% to 3% under a formula recommended by a panel Congress set up to advise Medicare officials on future rates and changes in Medicare's prospective pricing system.

The recommendation by the Prospective Payment Assessment Commission (PROPAC) contrasts with a Reagan Administration budget proposal to freeze the 1986 rates for each of the program's 468 diagnosis related groups. Payments to hospitals in fiscal 1986 would be from $320 to $960 million greater under the PROPAC proposal than in the Administration plan.

When Congress created PROPAC in the same law that set up the DRG payments, it said that after 1986, the Secretary of Health and Human Services should consult with PROPAC in the development of new rates. HHS is not required to accept PROPAC's advice, however, and the reaction of Congress and the Reagan Administration to the commission's recommendations suggested 1986 rate increases could serve as a key test of PROPAC's influence and future.

Adopted unanimously by the 15 PROPAC members, the rate update is one of 21 recommendations included in a report that PROPAC presented to Congress April 1. Other recommendations call for improving a wage index that many believe is unfair to rural hospitals; development of special rates for hospitals that treat an especially large percentage of indigent patients; and "recalibration" or revision of the relative weights of the DRGs in 1986.

The commissioners also studied several procedures where the current DRG assignments and weights have been questioned. They concluded that cases in which percutaneous transluminal coronary angioplasty (PTCA) is the principal procedure should be temporarily reassigned from DRG 108 to DRG 112. Study on this issue will continue, however, and the procedure may be reassigned to DRG 125 at some later date.

On the other hand, the PROPAC members recommended, the DRGs involving cardiac pacemaker implants, bone marrow transplantation, and cataract extractions and intraocular lens implants should not be altered until the DRS weights are recalibrated. PROPAC has submitted an additional report on its pacemaker recommendations to Congress and will continue to study all of the above procedures.

* * *

PROPAC Pacemaker Report

Despite indications that flawed data may have been used to construct Medicare diagnosis related groups (DRGs) affecting cardiac pacemaker implantations, no adjustments in the pacemaker DRGs should be made at the present time, the Prospective Assessment Commission (PROPAC) has told Congress.

In a report released earlier this month, the commission pledged continued watchfulness for possible quality deterioration in pacemaker services in the future. The advisory group also will do further studies to try to determine whether DRG adjustments for wages, location and other factors may lead to unjustified pacemaker payment variations that discriminate against certain types of hospitals.

The report recommended nonetheless that any adjustments in the four pacemaker DRGs (115, 116, 117 and 118) be made only as part of the overall recalibration of the weights used as a measure of the relative resource use of each of 468 DRGs. Congress had directed that the weights be recalibrated for fiscal 1986 and at least every four years thereafter.

Mandated in the 1984 Deficit Reduction

Act, the PROPAC pacemaker report estimated that pacemaker DRG payments cover from 84% to 109% of hospital costs for these services. Since this compared to an average of 90% for DRG payments for all hospital discharges, PROPAC concluded that the current pacemaker payments are "appropriate".

PROPAC did find problems in the 1981 data used to construct the pacemaker DRGs. The report suggested that some of the problems may disappear under the DRG system's incentives for better record- keeping and more efficient care, however. It concluded that a special adjustment was not justified now because the same problems affect all other DRGs as well and because some of the data may have understated DRG costs while other data overstated it, leaving the overall impact on the pacemaker prices unclear.

The report entitled "A Report on the Appropriateness of Medicare Hospital Payments for Pacemaker Implantation" was presented to the House Ways and Means and Senate Finance Committees. It is available by writing to PROPAC at 300 7th Street, SW, Suite #301B, Washington, DC 20024 or by calling 202/453-3986.

* * *

Florida HMOs

The Reagan Administration proceeded with a new Medicare HMO option even though it was aware of administrative snarls that indicated that "the federal government cannot operate the program in one state let alone the other 49," Rep. Larry Smith (D-FL) has charged.

Smith based his comments on a General Accounting Office study he requested after problems developed in four Medicare demonstration HMOs in south Florida. The study pointed to program administration difficulties at the Florida Blue Cross and Blue Shield Plan and within the Health Care Financing Administration.

HCFA retorted that the problems GAO identified in Florida "do not currently exist" and said it is "unfortunate" that the GAO left the "impression that problems experienced in the demonstration projects have either been ignored or not corrected, which is not the case."

A Blue Cross and Blue Shield spokesman said the plan had not yet seen the GAO report.

The four Florida HMOs have enrolled about 112,000 Medicare members, or about half of all Medicare enrollees in 26 HMO demonstration plans that served as a pilot for a Medicare prospective payment option. The option, which went into effect February 1, is expected to encourage up 800,000 Medicare beneficiaries to switch to HMOs or similar plans in the next few years and to double the current number of Medicare HMO enrollees. Concerns such as those raised in Florida had prompted Rep. Smith and the American Medical Association to seek delays in the implementation of the option.

Although a later GAO study will look at the quality of care provided in the HMOs, HCFA estimates that about 96% of the complaints about the Florida HMOs have revolved around administrative issues, particularly the enrollment and disenrollment procedures.

The current study found two basic flaws in the Florida demonstration. The first involved an error-ridden process for coordinating Medicare HMO payments with the traditional Medicare program's payment. The second centered on a four to eight week waiting period between the time the beneficiary enrolled in or left the HMO and the date on which his new coverage began.

A central factor in the payment coordination problem, according to GAO, was a faulty federal computer system that could not identify whether a Medicare beneficiary was an HMO member until 16 to 37 days after the individual had enrolled in or disenrolled from the HMO.

The federal record of enrollment is important to enforce a provision "locking" beneficiaries in to the services of the HMO and preventing payments for both the HMO coverage and the non-HMO services that would have been provided under the traditional Medicare plan.

In looking at about nineteen months worth of claims for the Florida HMO members, GAO found that of 6,737 Medicare beneficiaries (or 6.4% of the Medicare HMO enrollees) ran up about $2.6 million worth of bills for physician services outside of and unauthorized by the HMO.

About $700,000 of the claims were paid by the Blues plan even though they should have been denied and even though in some cases the HMO had also paid for these services. Another $1.9 million in claims were correctly denied by the Blues, but caused problems for some beneficiaries who faced substantial bills that for 64 patients totalled $5,000 each or more.

In the majority (53%) of these 64 cases, the HMO paid the bill more than $13,000 in one case either because it had authorized the service or because it believed the beneficiary was not at fault or could not afford to pay.

In another 22% of cases, the physicians who had provided the out-of-plan services went without payment. The unpaid bills totalled more than $26,000 in the case of one 70-year-old man.

* * *

Super-PRO

Having scaled down their demands for a contractor to monitor Medicare's Peer Review Organizations (PROs), Health Care Financing Administration officials are preparing to reopen bids for the so-called Super-Pro contract.

All four bids in an earlier round of bidding, including one from the American Medical Association were turned down as nonresponsive, reportedly in large part because they exceeded the funds available for the contract.

Although HCFA officials said they could not discuss funding in a competitive bidding situation, they did acknowledge that the work load the Super-PRO will be asked to perform has been reduced. Industry sources said they believed HCFA wants to hold the price of the contract to about $5 or $6 million.

In addition to the usual notification in the Commerce Business Daily, the Medicare officials are seeking widespread press announcements of the latest bid solicitation. The objective is to bring the contract to the attention of more potential bidders. A request for bid proposals (RFPs) was to be carried in Commerce Business Daily in early April.

This new solicitation differs from the earlier one in that it appears to be worded so as to appeal to a wider variety of organizations. It also requires semi-annual reports rather than quarterly and has reduced the types of review requested.

Pennsylvania PRO Problems

Federal Medicare officials, displeased with a logjam of unreviewed claims and other performance problems have notified the five month old Pennsylvania Peer Review Organization (PaPRO) that the PRO's contract will be terminated unless the 53,000 claims backlog is eliminated by June 20.

The action came after officials with the Health Care Financing Administration rejected two corrective action plans submitted by the PRO. HCFA did, however, agree to release contract funds that had been withheld from the PRO in December, January and February.

PaPRO may still retain its contract to review the claims for hospitalized Medicare patients if it eliminates the claims backlog and meets other commitments handed down by HCFA officers. The notification of intent to terminate puts HCFA officials in a position of initiating negotiations for a new PRO contract in Pennsylvania in the interim, however, if it appears that PaPRO will not meet the commitments.

* * *

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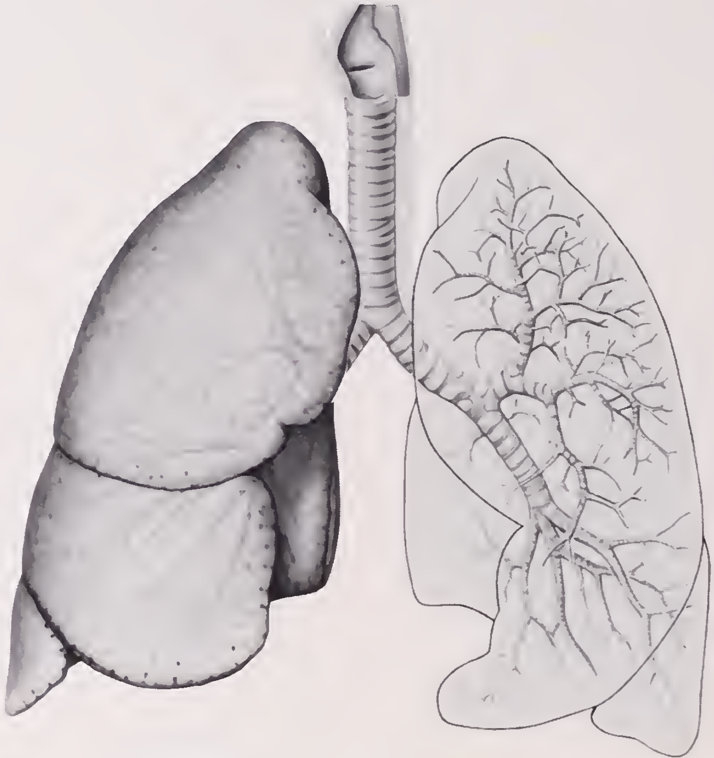

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Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor Lilly) There are however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0.20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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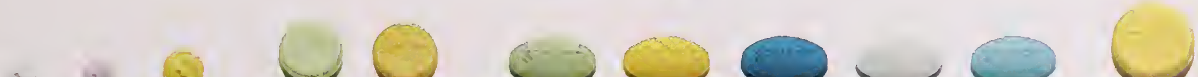

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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor perspiration, and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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Review articles will be considered, and should generally be limited to less than 4,000 words and approximately 30 references.

Manuscripts describing original clinical or laboratory research should be limited to 2,000 words and approximately 20 references.

Acknowledgements must be given when material from other publications is included. Provide names of authors, title of article, title of journal or book, volume number, pages, month and year, and publisher's permission to reprint.

Always send a covering letter or letter of transmittal with each manuscript, and refer to the manuscript by its title, in the letter and all correspondence. Do not send a manuscript that was published elsewhere.

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CBO Budget Options

Congress could consider several alternatives to President Reagan's proposal to continue a freeze on all physicians' Medicare fees for another year, the Congressional Budget office has suggested.

One alternative would permit fees to rise for some physicians who signed Medicare participating agreements in fiscal 1985. Others are variations on a Medicare fee schedule.

Spelled out in a recent CBO report entitled "Reducing the Deficity Spending and Revenue Options," the package of alternatives also offers provisions to moderate the President's recommended reductions in Medicare payments for graduate medical education. It offers no alternatives to hospital rates.

Suggested revenue-raising proposals include

(Continued on page 11A)

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WashingtoNotes

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a tax on employer-paid health insurance premiums and several alternatives for increasing Medicare premiums, deductibles and taxes. The CBO hikes in Medicare premiums, deductibles and taxes would cost beneficiaries more than the President's proposals.

In looking at curbs on Medicare payments to physicians, the CBO estimated that the Reagan Administration's plan to extend the current freeze on Medicare customary and prevailing fees until October 1, 1986 would save $490 million is fiscal 1986 and $3.2 billion through 1990.

As an alternative, the Budget office suggested, Congress could update the customary fee allowances for individual participating physicians. Since the ceilings on then prevailing community rates would remain frozen, only participating physicians with fees lower than the prevailing fee ceiling would receive fee increases. Or, the report advised, Congress could pay physicians according to a fee schedule based on the national average allowed for each procedure in the previous year. The schedule would be adjusted for regional cost variations and updated in following years by the increase in the Medicare economic index.

* * *

Mandatory Second Opinions

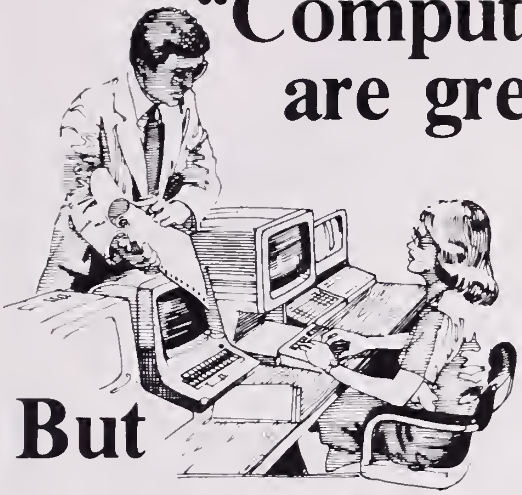
Medicare might save more than $1 billion a year if patients recommended for nine types of elective surgery were required to seek a second opinion, according to a report from the Senate Aging Committee.

The report, estimated that the nine types of surgery (pacemaker, cataract, gall bladder, prostate, knee, hysterectomy, back, hernia and hemorrhoidectomy) are performed unnessarily in 17% to 35% of cases. It projected Medicare savings of $734 to $1.18 billion.

Senate Aging Committee Chairman Sen. John Heinz (R-PA), who released the report at a March 14 hearing, said he may introduce legislation to require second surgical opinions

(Continued on page 12A)

"Computers are great.



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in Medicare and Medicaid. Other committee members, including ranking Ohio Democrat John Glenn, appeared ready to cosponsor such legislation, which Heinz indicated that he may push as a substitute for budget proposals to increase beneficiary cost-sharing.

Heinz is siding with Department of Health and Human Services Inspector General Richard Kusserow in a long-simmering dispute with the Health Care Financing Administration. The dispute traces back to the IG's recommendation in early 1983 that Medicare and Medicaid require second surgical opinions for the nine procedures.

Medicare has paid for voluntary second opinions since 1977 and both the IG and HCFA agree that the voluntary program has had little impact on surgical rates. Both offices also concur that Medicaid programs mandat-

(Continued on page 14A)

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WashingtoNotes

(Continued from page 12A)

ing second opinions for selected procedures appear to have saved money, $1 million a year in Massachusetts, for instance.

Both also agree that most savings from the mandated second opinions are not directly due to patient's foregoing surgery but stem instead from the "sentinel effect" in which physicians simply don't recommend certain procedures because they are aware that their decision will be questioned. About 90% of the Massachusetts savings were attributed to the "sentinel effect," for example.

As replayed before the Aging Committee, however, the argument between the two HHS agencies really centers on what mechanism should be used to produce the desired sentinel effect. According to HCFA official James Scott, mandatory second opinions would merely duplicate the efforts of Medicare's new Peer Review Organizations and some state Medicaid review mechanism. According to Kusserow, the PROs are an inadequate guard against unnecessary surgery because they have no authority to look at outpatient procedures.

A carefully-selected group of witnesses — including a witness from the American Association of Retired Persons and Cornell researcher Eugene McCarthy, M.D., who has long advocated second surgical opinion programs — also called for mandatory Medicare second opinions. They said such programs offer an excuse for patients who fear they will offend their physician if they seek a voluntary second opinion.

Several of the witnesses suggested that physicians do not oppose second surgical opinions as much as their patients believe they do, and Kusserow asserted that mandatory second opinions might protect physicians against malpractice awards.

Medical organizations, including the American Medical Association, have generally supported voluntary second opinions but opposed mandatory plans. Several of the medical groups which had expressed an interest in testifying, however, were permitted only to submit statements after the hearing.

(Continued on page 219)

efore prescribing, see complete prescribing information in SK&F CO.
erature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ontraindications: Concomitant use with other potassium-sparing agents
ıch as spironolactone or amiloride. Further use in anuria, progressive
nal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
otassium. Hypersensitivity to either component or other sulfonamide-
erived drugs.

**/arnings: Do not use potassium supplements, dietary or otherwise, unless
ypokalemia develops or dietary intake of potassium is markedly impaired.**
supplementary potassium is needed, potassium tablets should not be
sed. Hyperkalemia can occur, and has been associated with cardiac irregu-
rities. It is more likely in the severely ill, with urine volume less than
ne liter/day, the elderly and diabetics with suspected or confirmed renal
sufficiency. Periodically, serum K$^+$ levels should be determined. If hyper-
alemia develops, substitute a thiazide alone, restrict K$^+$ intake. **Asso-
ated widened QRS complex or arrhythmia requires prompt additional
erapy.** Thiazides cross the placental barrier and appear in cord blood.
se in pregnancy requires weighing anticipated benefits against possible
azards, including fetal or neonatal jaundice, thrombocytopenia, other
dverse reactions seen in adults. Thiazides appear and triamterene may
ppear in breast milk. If their use is essential, the patient should stop
ursing. Adequate information on use in children is not available. Sensitivity
actions may occur in patients with or without a history of allergy or
onchial asthma. Possible exacerbation or activation of systemic lupus
ythematosus has been reported with thiazide diuretics.

recautions: The bioavailability of the hydrochlorothiazide component of
yazide' is about 50% of the bioavailability of the single entity. Theoreti-
ılly, a patient transferred from the single entities of Dyrenium (triamterene,
K&F CO.) and hydrochlorothiazide may show an increase in blood pressure
fluid retention. Similarly, it is also possible that the lesser hydro-
ılorothiazide bioavailability could lead to increased serum potassium levels.
owever, extensive clinical experience with 'Dyazide' suggests that these
onditions have not been commonly observed in clinical practice. Do
eriodic serum electrolyte determinations (particularly important in patients
omiting excessively or receiving parenteral fluids, and during concurrent
se with amphotericin B or corticosteroids or corticotropin [ACTH]).
eriodic BUN and serum creatinine determinations should be made,
specially in the elderly, diabetics or those with suspected or confirmed
nal insufficiency. Cumulative effects of the drug may develop in patients
ith impaired renal function. Thiazides should be used with caution in
atients with impaired hepatic function. They can precipitate coma in
atients with severe liver disease. Observe regularly for possible blood
yscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias
ave been reported in patients receiving triamterene, and leukopenia,
rombocytopenia, agranulocytosis, and aplastic and hemolytic anemia
ave been reported with thiazides. Thiazides may cause manifestation of
tent diabetes mellitus. The effects of oral anticoagulants may be
ecreased when used concurrently with hydrochlorothiazide; dosage adjust-
ents may be necessary. Clinically insignificant reductions in arterial
sponsiveness to norepinephrine have been reported. Thiazides have also
een shown to increase the paralyzing effect of nondepolarizing muscle
laxants such as tubocurarine. Triamterene is a weak folic acid antagonist.
o periodic blood studies in cirrhotics with splenomegaly. Antihypertensive
fects may be enhanced in post-sympathectomy patients. Use cautiously
surgical patients. Triamterene has been found in renal stones in asso-
ation with the other usual calculus components. Therefore, 'Dyazide'
ould be used with caution in patients with histories of stone formation.
few occurrences of acute renal failure have been reported in patients on
yazide' when treated with indomethacin. Therefore, caution is advised in
lministering nonsteroidal anti-inflammatory agents with 'Dyazide'. The
llowing may occur: transient elevated BUN or creatinine or both, hyper-
ycemia and glycosuria (diabetic insulin requirements may be altered),
yperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing
kali reserve with possible metabolic acidosis. 'Dyazide' interferes with
iorescent measurement of quinidine. Hypokalemia is uncommon with
yazide', but should it develop, corrective measures should be taken such
s potassium supplementation or increased dietary intake of potassium-
ch foods. Corrective measures should be instituted cautiously and serum
otassium levels determined. Discontinue corrective measures and
yazide' should laboratory values reveal elevated serum potassium.
hloride deficit may occur as well as dilutional hyponatremia. Concurrent
se with chlorpropamide may increase the risk of severe hyponatremia.
erum PBI levels may decrease without signs of thyroid disturbance. Cal-
um excretion is decreased by thiazides. 'Dyazide' should be withdrawn
efore conducting tests for parathyroid function.

iiazides may add to or potentiate the action of other antihypertensive
ugs.

uretics reduce renal clearance of lithium and increase the risk of lithium
xicity.

dverse Reactions: Muscle cramps, weakness, dizziness, headache, dry
outh; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermat-
ogical conditions; nausea and vomiting, diarrhea, constipation, other
astrointestinal disturbances; postural hypotension (may be aggravated by
cohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias,
terus, pancreatitis, xanthopsia and respiratory distress including pneu-
onitis and pulmonary edema, transient blurred vision, sialadenitis, and
ertigo have occurred with thiazides alone. Triamterene has been found in
nal stones in association with other usual calculus components. Rare
cidents of acute interstitial nephritis have been reported. Impotence has
een reported in a few patients on 'Dyazide', although a causal relationship
as not been established.

**upplied: 'Dyazide' is supplied as a red and white capsule, in bottles of
000 capsules; Single Unit Packages (unit-dose) of 100 (intended for
stitutional use only); in Patient-Pak™ unit-of-use bottles of 100.**
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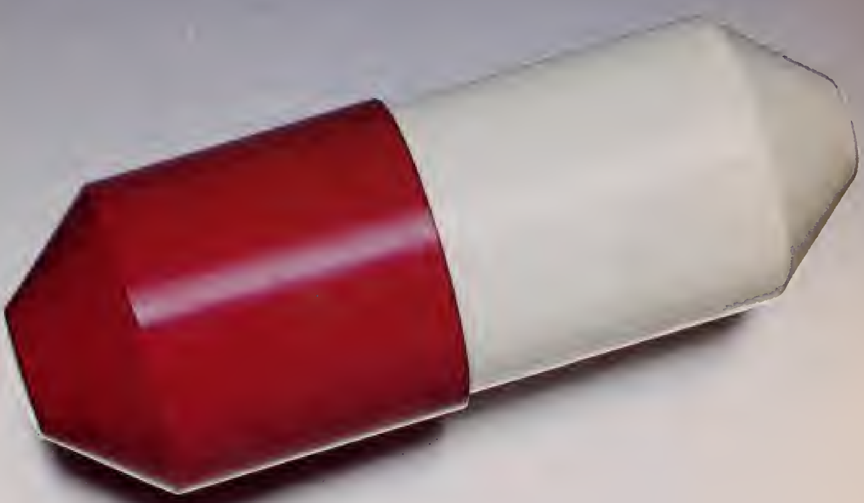

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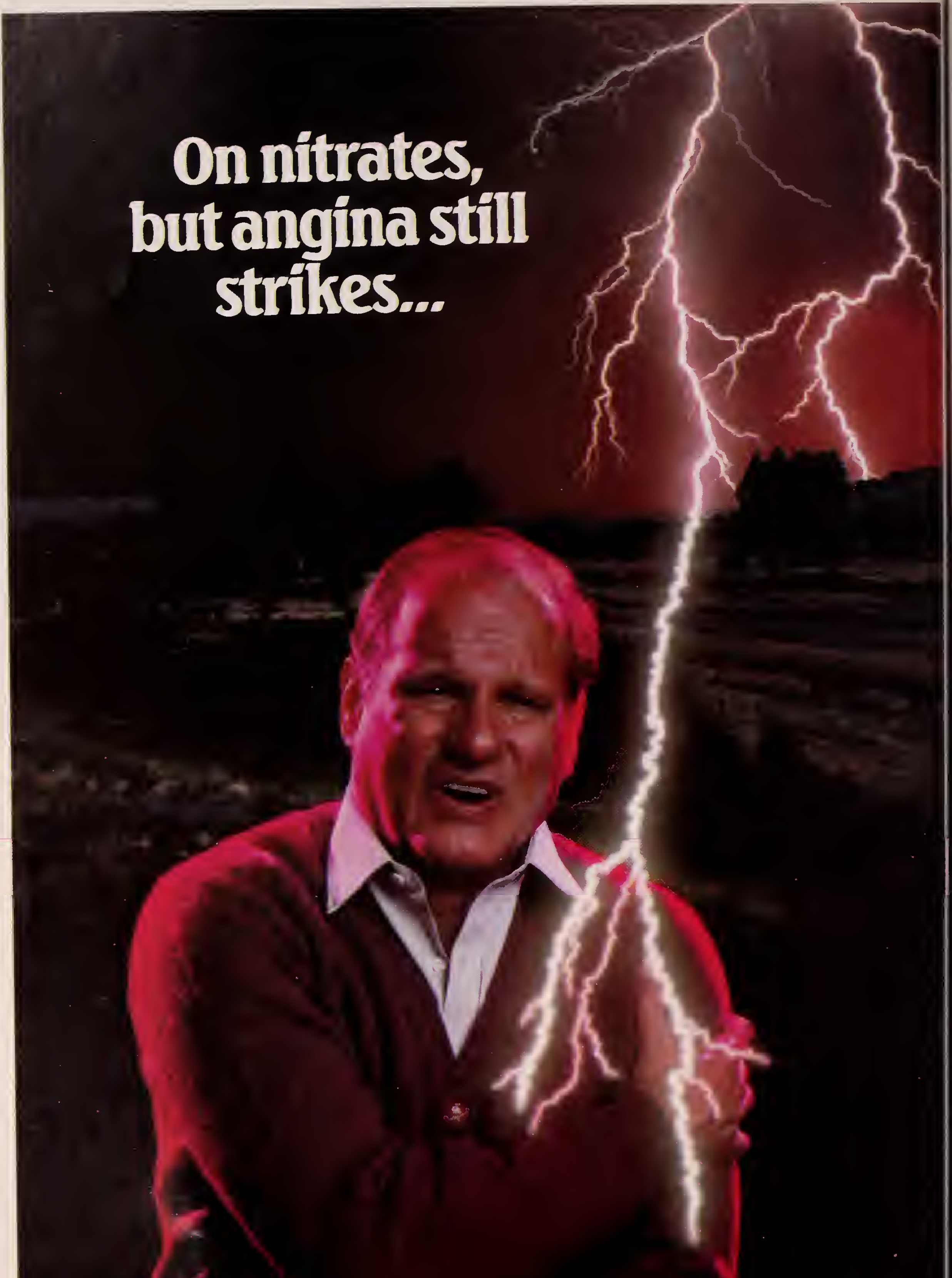
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Please see brief summary on following page.

ISOPTIN®

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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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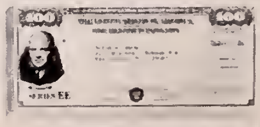

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THE NEBRASKA MEDICAL JOURNAL

The Need for Chemical Disclosure Legislation

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NEBRASKA does not currently have any legislation on the subject of the right to know about chemical hazards emanating from the workplace. There is a strong public health need for responsible legislation of this nature. The federal government, in November, 1983, promulgated a "hazard communication."[1] This communication inadequately protects workers from workplace-related chemical hazards. Thus, there is a strong need for a revised, more comprehensive federal hazard communication.

Millions of Americans are being exposed daily to an already large, and growing number of hazardous substances. Industry uses an estimated 63,000 commercial chemicals to make a wide range of products, ranging from pharmaceuticals to pesticides, plastics and paints.[2] About 1,000 new chemicals are produced annually.[3] Unfortunately only a few of the new, possibly toxic chemicals have been fully tested to determine possible risks associated with long-term exposure. Every day the chemical and petroleum industries produce about 275 million gallons of gasoline, 2.5 million pounds of pesticides and herbicides, and almost 723,000 tons of dangerous wastes.[4] An estimated 25 million American workers are exposed to one or more of the nearly 8,000 hazards identified by the National Institute for Occupational Safety and Health.[5] As many as 40 to 50 million Americans may have been exposed at some point to one or more of the hazardous chemicals regulated by the federal Occupational Safety and Health Administration (OSHA).

Exposure to hazardous substances may potentially imperil the public health. In 1977 the Bureau of Labor Statistics (BLS) reported approximately 162,000 new cases of occupational illness, and 143,500 in 1978.[5] In 1983 the chemical industry reported 5.2 occupational injuries per 100 workers.[4] The United States Public Health Service estimates that up to 390,000 workers contract work-related diseases annually.[3] Occupational exposure to hazardous substances may be associated with mortality. Job-related diseases account for an estimated 100,000 deaths yearly. An estimated 17,000 workers die each year from cancer caused by exposure to potentially hazardous chemicals.[6]

It is vitally important for persons to be aware of possibly harmful exposures to chemical hazards emanating from the workplace. Prompt, complete awareness of the nature of possible harmful exposures may help affected persons obtain adequate, timely medical care. It may further assist, in appropriate instances, with the instituting of legal remedies afforded by state worker compensation programs. Many states have recognized the value of right to know laws, and have promulgated laws of this type. Illinois, Rhode Island, Delaware, Maryland, Minnesota, California, and Florida are selected states which have recently enacted legislation affording workers the right to know about chemical hazards in the workplace.[7-13]

Since as many as 50 million Americans may have been exposed to hazardous chemicals, it is further important to enact legislation which specifically extends right to know protection to members of the general public. Community right to know protection may assist affected community residents in making knowledgeable and reasoned decisions about the continued personal costs of employment or residence at a particular place, and the need for corrective action. Several state governments, including Pennsylvania, New Jersey, and Iowa, have passed community right to know laws designed to safeguard the health of citizens in the community at large.[14-16] In some instances, local governmental bodies have similarly enacted community right to know ordinances, or laws. For instance, several cities in Ohio, including Canton, Akron, and Cincinnati, have passed community right to know ordinances.[17-19]

Nebraska should join the growing list of states which have enacted responsible right to know laws. Particular attention should be directed towards including community-oriented provisions in a possible state right to know law.

In November, 1983, the federal government published a "hazard communication" in the Federal Register.[1] This communication requires chemical manufacturers and importers to assess the hazards of chemicals which they produce or import. All employers having workplaces in the manufacturing division must provide information to their employees about hazardous chemicals by means of hazard communication programs. The programs shall include labels, training, material safety data sheets, and access to written records. An issue of possible preemption of proposed, and extant, state right to know laws is raised because the federal hazard communication is intended specifically to preempt any state law pertaining to communicating information about chemical hazards to workers in manufacturing.

The federal hazard communication does an inadequate job of protecting the public health. In 1978 employees in the manufacturing sector accounted for less than 30% of total employment.[5] An estimated 60 million workers are left unprotected by the federal communication.[20] The ultimate fate of the federal communication, and its possible effect on state right to know legislation, will probably be decided by litigation. A lawsuit has already been filed in federal court by a coalition of groups, including the Public Citizen Health Research Group. The lawsuit is petitioning the court for review of the federal hazard communication in part on the ground that it is arbitrary and capricious for allegedly failing to provide adequate information to workers about workplace hazards.[21] This case has been consolidated with similar petitions brought by several states, including Illinois, Massachusetts, and New York. The consolidated case is scheduled to be listed for disposition sometime in early 1985.

The right to know about chemical hazards in the workplace raises issues of major social significance which are closely associated with the public health. It is therefore important for the medical community to pursue active, informed action in this area. In addition to support for a responsible state right to know law, it is further important to support measures providing for a revised, more comprehensive federal hazard communication. Particular attention should be directed towards revision of the federal hazard communication so as to extend right to know protection to all workers in industries and services not covered by the current communication, including construction, agriculture, transportation, health care, public safety, and other industries and services.

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Heat Stroke, Stress, and Malignant Hyperthermia

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FATAL and near fatal response to stress associated with the apparently familial autosomal dominant muscular disease, malignant hyperthermia, are being increasingly reported in situations not related to anesthesia or drugs. The syndrome has been reported quite frequently after significant trauma or stress.

The cases we have studied show a number of instances wherein emotional, physiologic stress, or trauma have initiated symptoms of the syndrome. Several cases of stress induced disease have been reported recently.[1] Such a combination of malignant hyperthermic symptoms in situations of stress lead to the conclusion that some cases of atypical heat stroke may not be true heat stroke. Cases with sudden death, hyperpotassemia or early myonecrosis are particularly suspect. Some degree of understanding of malignant hyperthermia is necessary for those persons dealing with persons at risk for stress in heat.[1]

The tragedy of heat stroke is its occurrence in youthful persons engaged in military training, sports, and the labor force. The demands upon the participant often precludes adequate fluid intake, rest, or time off.

Measures for prevention for heat stroke are adequate rest, hydration and fluid replacement with periodic rest to allow cooling. Such common sense measures should be understood by military instructors, employers, coaches, and others dealing with persons exercising in high heat situations.

Febrile responses to certain anesthetic agents with fatal or near fatal outcomes have been recognized since 1937,[2] but it was not until 1960 that the symptom complex known as malignant hyperthermia was described in detail.[3] Denborough's early report involved use of potent inhalation anesthetics combined with muscle relaxants.[3,4,5] The typical response was a fulminant crisis consisting of fever, tachycardia, tachypnea, and cyanosis. Malignant hyperthermia (MH) until recently was considered a rare pharmacogenic problem unlikely to be encountered by the individual clinician.[1,6] With an increased awareness, it has become apparent that the syndrome is not so rare and that its occurrence is not limited to the operating room environment.[7,1,5]

Presentation and Pathology in Heat Stroke

Malamud has fully described the pathological changes in heat stroke which are widespread in organs and systems. Varied etiologies for heat stroke give identical pathological findings. The typical case of MH gives a similar picture; cases of early death have damage mainly limited to the central nervous system.[8,9]

The changes typically seen in heat stroke and MH are tissue hemorrhage, degenerative tissue swelling, and loss of cell and tissue definition. Edema of brain tissue is usually noted with brain petechiae common about the third and fourth ventricles. Subendocardial hemorrhage, renal congestion, liver necrosis, and pancreatic hemorrhage are frequently seen. The adrenals are quite often spared. Disseminated intravascular coagulopathy is sometimes noted, as it is in MH.[1,8]

Onset of heat stroke is often very rapid with cases heralded by weakness, headache, irrationality, and confusion.[10] Those cases caused by ambient heat accumulation seem to be slower in the onset than cases resulting from physiological exertion. In fatal instances, death is often seen in several hours to a few days and is usually the result of central nervous system damage. Late deaths at one or two weeks are most often secondary to renal, cardiac or liver failure and occasionally hemorrhages or coagulation problems.[10,11,1,8]

Dehydration is not necessarily present and sodium levels are usually normal or high at admission.[12,7] Heat stroke most often is associated with acidosis and a low potassium level.

This contrasts with MH where the marked acidosis is accompanied by a very high serum potassium level.[1]

Both heat stroke and MH are attended by muscle rigidity in many cases. Muscle damage and muscle enzyme elevation are noted in both. Both are accompanied by myoglobinuria and renal failure in very severe cases.[10,11,13,1,12,8,14]

The diagnosis of classical heat stroke is usually predicated upon the loss of consciousness associated with a combination of stress and elevated core temperature. Treatment in heat stroke is rapid cooling with ice baths, alcohol sponging, cold fluids, rest and if needed, hypnotic drugs, heparin for coagulopathy and replacement of water. Dialysis for renal failure is sometimes needed and sodium bicarbonate is suggested for the acidosis.

Steroids and salicylates are of no great use and hence not indicated. Beta blocking agents can cause hypotension and should not be used. It is unwise to use lactated solutions in the presence of lactic acidosis. Sustaining circulation with isoproterenol is not indicated as it reduces renal perfusion and can augment organ failure. Its use has been condemned in several studies. Judicious use of Mannitol and adequate water input to maintain volume and pressure are probably more appropriate treatment.

Malignant Hyperthermia Pathophysiology

Muscle is the target organ in MH. Apparently the inciting or triggering events cause the release of calcium from the storage membranes (sarcoplasmic reticulum) into the myoplasm.[15,16,17,6,9] This results in a sustained sarcomeric contraction with variable muscle rigidity. In consequence, the metabolism is accelerated with high heat and carbon dioxide production plus increased oxygen consumption. Early in this sequence the peripheral circulation can dissipate heat but after vasoconstriction, which occurs soon, the blood is shunted away from the periphery.[1] The core temperature then rises precipitiously. This stage is characterized by a blotchy, mottled cyanosis.

Hypoxia increases anaerobic metabolism and lactic acidosis results. As acidosis increases, there is loss of muscle cell integrity resulting in multiple electrolyte aberrations. Especially ominous is a transient calcium rise. Later a drop in calcium is noted, probably from renal excretion.[1,6]

At the same time serum potassium rises rapidly as a result of cellular damage. If this rise exceeds 7.0 mEq per liter, there is an increase in mortality. Cardiac arrythmias probably result from acidosis, electrolyte aberrations and anoxia, though a direct cardiac effect remains a possibility. As muscle tissue is the affected organ, there is massive swelling and rhabdomyolysis with subsequent myoglobinuria. Rapid respirations are an attempt to blow off carbon dioxide produced in this hypermetabolic state. When fully developed, the syndrome may produce consumption coagulopathy. Urinary output decreases, renal solute load rises, tubular damage can occur, and the BUN rises. Acute pulmonary edema can be seen.[18,1,6]

Treatment of Maglignant Hyperthermia

The patient with malignant hyperthermia should be hyperventilated with oxygen. Sodium bicarbonate (8.4 percent solution) should be given intravenously in a dose of four ml per kg body weight and repeated as needed until pH and blood gases approach normal values. Mannitol in usual doses helps to maintain urinary output, and clears myoglobin and excessive sodium. Approximately 50 ml of 50 percent glucose administered intravenously with 50 units of insulin aids in the reduction of hyperkalemia. Procainamide will often control the arrhythmias seen in this condition.[18,1,6]

Cooling of the patient is the first consideration. Immersion in an ice-and-water bath and exposure to electric fans works well. Refrigerated saline and non-lactated solutions administered intravenously have been helpful. Cooling is stopped when the patient's temperature drops to 38 degrees Celsius and resumed when it rises above this level.[1,6]

Dantrolene sodium intravenously is a specific treatment in doses of one or two mg/kg and repeated periodically until acidosis, tachycardia, and muscle rigidity are controlled. These doses can be repeated every 10-15 minutes until control of symptoms is apparent, or a cumulative dose of 10 or 12 mg/Kg has been given.[1,17,6]

Physiological monitoring with electrocardiography, central venous pressure, temperature, and blood pressure need to be done until the patient is stable. The blood gases should be checked at 10 to 15 minute intervals. A urinary catheter should be used to evaluate the quantity and quality of the urine. Levels of serum electrolytes, serum glutamic oxaloacetic transaminase, creatine phosphokinase, and creatinine should be determined at intervals to assess the response of the patient to treatment. Favorable prognostic signs include lightening of coma, which is often heralded by restlessness; a return of reflexes, a drop to normal temperature and blood pressure, reduced heart rate, improved renal output, and return of consciousness. Upon recovery, the patient will complain of severe muscle pain, plus tenderness and intense muscle swelling for days. Weakness and easy fatigability persists as a complaint for several months in most patients.[6]

Dantrolene in Treatment of Malignant Hyperthermia and Heat Stress

Dantrolene sodium is an analogue of diphenylhydantoin. The drug apparently reduces the calcium outflow into the myoplasm from the storage membranes.[6] This site of action and a potential defect in the sarcoplasmic reticulum in malignant hyperthermia led us to study the effects of the drug in hyperthermic swine.[18,17] Unknown to us, a parallel study in Landrace pigs was reported by Harrison shortly before our work on Poland China swine was presented. The results were almost identical in both studies.[18,17]

As a consequence of its effectiveness in porcine malignant hyperthermia, dantrolene sodium prophylaxis was used in 71 patients (approximately 80 anesthesias with family history of malignant hyperthermia). The following prophylactic treatment was utilized: Dantrolene 2.2 mg per Kg of body weight was given orally at 12 and four hours prior to induction of anesthesia.[18,6] The ideal dosage has yet to be firmly established, but it would appear to be approximately two to four mg per Kg of body weight. This has been effective preanesthetic prophylaxis in both swine and humans.[18,6]

Studies in pigs indicated that dosages of dantrolene two or three times the prophylactic levels are needed for treatment of the triggered syndrome in swine.[18,17] This increased dosage probably will be used with the parenteral form. Since August, 1979, a lyophilized preparation of dantrolene for intravenous use has been available. Britt and associates reported 12 patients with malignant hyperthermia who were successfully treated with dantrolene in dosages of 10 to 12 mg per Kg of body weight given intravenously. Wingard at the University of Nebraska Medical Center has successfully treated eight patients with intravenous dantrolene in this dosage range.[6]

The use of relatively small doses of dantrolene for short periods of time, as described, has caused no serious effects. In the higher dosages used for treatment, there may be a slight rise in blood pressure and pulse rate. Longterm use has not been necessary in this syndrome.[6,7]

Discussion

A remarkable contrast between the human and porcine syndromes is the ease with which the disease can be triggered by stress in the animal. The reports of Groenert[7] and Wingard[14] suggest that the syndrome in awake humans may not be so rare. Symptoms may be more subtle in the human, or modified because man can adapt his environment or alter his exciting factors.

Malignant hyperthermia in humans and porcine stress syndrome appear to be the same disease. Lactic acidosis, hyperpotassemia, intolerance to stress, fever, muscle fasciculations, cardiac arrhythmia, cyanosis and mottling, rigor of muscles, shock-like collapse, rhabdomyolysis, and similar blood-gas changes are noted in both species.[1,6]

Physiologic and emotional stress have been reported to be associated with several cases.[1,7] Similarities between classically described heat stroke and malignant hyperthermia and their mutual relationship to physiologic stress are a problem for the military surgeon, sports medicine physician, and industrial practitioner.[1] A major question remains: Are some or many cases previously classified as classical heat stroke in reality a stress-induced malignant hyperthermic crisis? The problem is one of placing these stress-induced syndromes into clear perspective, allowing optimal management and appropriate medical discussion of these entities.

A review of heat stroke cases from various writers does not allow an accurate identification of cases which are clearly a stress induced malignant hyperthermia. There are several cases reported with myonecrotic features, with rapid onset of myoglobinuria, acidosis and paradoxically high serum potassium levels, which must be suspected as being cases of stress induced malignant hyperthermia.

With no accurate chemical screening test, the only effective precaution against malignant hyperthermia is a thorough family and personal history. The association of the syndrome with congential musculoskeletal abnormalities can alert those responsible for care to an increase in hazard. The presence of the syndrome is most suspect in patients with a large muscle mass who demonstrate localized weakness, who complain of cramping in the limbs, twitching and intolerance to exercise in hot weather, and who sometimes demonstrate acrocyanosis (blotching cyanosis of the hands and feet in stress). Associated with the syndrome are scoliosis, kypnosis, hernias, club feet, strabismus and recurrent dislocation of joints, which can aid in increasing suspicions of susceptibility. A carefully taken family history for heat stress disease or death cannot be overemphasized.

The use of agents that reduce concentrations of myoplasmic calcium appear to reduce the hazard and aid in recovery. Dantrolene is such an agent, having been demonstrated to inhibit calcium release from the sarcotubular system. It is effective in stopping the excessive contractility of muscle in most persons with malignant hyperthermia. The drug has been effectively used intravenously for treatment in pigs and humans.

Summary

Malignant hyperthermia is a consideration in all patients under stress who develop rigidity, tachycardia, tachypnea, acidosis, low p02, high pC02 and hyperpotassemia. Cases with myoglobinuria, myonecrosis, and high potassium are quite logically most suspect.[1] Those treating heat stroke cases must consider that some cases are indeed stress induced malignant hyperthermia (Human Stress Syndrome).

Thus, treatment prescribed in both heat stroke and malignant hyperthermia must emphasize rapid cooling, procainamide for cardiac arrhythmias, diuretics such as mannitol with adequate water intake to reduce myoglobin accumulation in the renal tubules, and the liberal use of sodium bicarbonate to combat acidosis. Vasopressors must be avoided. Curare-like muscle relaxants for spasm or twitching are contraindicated. Dantrolene sodium should be used in any cases with rigidity, myoglobinuria, or hyperpotassemia. This drug is safe in therapeutic and prophylactic doses, and is effective in reducing the symptoms of both anesthetic and stress-induced malignant hyperthermia. Dantrolene does not appear to be contraindicated in classical heat stroke and may well help to reduce the muscle pathology in this condition.[1]

Analysis of the nature of these syndromes indicates a need for prospective studies to clearly differentiate classical heat stroke from stress-induced malignant hyperthermia. Malignant hyperthermia is apparently an autosomally dominant inherited abnormality[4,20] that contributes significantly to the annual total of stress, anesthetic, and post-traumatic deaths.[18] Association of the syndrome with musculoskeletal abnormalities such as kyphosis, scoliosis, recurrent joint dislocations, club feet, as well as ptosis, strabismus, and hernias can help in recognition.

A suspicious history may only include unexplained fever following severe physiologic stress.[1] It has been postulated that sudden collapse and death occurring on the football practice field or other athletic endeavor may indeed be the result of a triggered malignant hyperthermia syndrome. A prospective study of heat stroke cases by muscle biopsy with caffeine-halothane challenge would assist in differentiating stress-induced malignant hyperthermia from classical heat stroke. Carefully standardized electrolyte and blood gas studies should be incorporated in the protocol as well.

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Superiority of Standing Orders to Start an IV During Cardiac Arrest Over Base Station Orders

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PARAMEDIC systems operate under standing orders, direct orders from physicians or nurses by radio, or a combination of both. Systems may not allow standing orders because of fear that such orders will not be followed correctly or that time will be wasted without being under the control of a physician or nurse.

We studied the difference in time to start an intravenous (IV) lifeline during out-of-hospital cardiac resuscitation with standing orders versus base station direction. Our findings show that standing orders significantly reduce the time necessary to initiate IV therapy.

Methods:

The study was conducted in the Omaha methropolitan area using data from out-of-hospital cardiac arrests which occurred between August 1, 1983 and February 1, 1984. The study region is covered by a two-tiered basic and advanced life support (paramedic) response. In this city, rescue personnel are full-time paid employees of the Fire Division. In the suburbs, rescue services are provided by volunteers.

The uniform prehospital arrest protocol in effect during the study peiod is noted in Figure 1. Paramedics had standing orders to initiate CPR, defibrillate if ventricular fibrillation was noted on arrival, and intubate. At the onset of the study period, all paramedics were given additional standing orders to proceed with IV insertion without the need to obtain radio permission from the base-station physician first. For the first five months after the protocol was changed, some paramedics (by habit) continued to call in to the base station to request permission from the physician to start an IV when they reached that point in the algorithm. This subgroup served as a control.

Rescue squad run and base station reports on all out-of-hospital cardiac arrests occuring in the Omaha metropolitan area during the study period were reviewed. The time from arrival of the paramedic squad on the scene until the IV was reported to the base station to be running successfully was noted from the run sheet or base station report. Cardiac arrests in children (under age 17), arrests due to trauma, arrests due to terminal disease where aggressive pre-hospital treatment was not carried out, and primary respiratory arrests were excluded. Arrests which occured after arrival of the rescue squad were not included since the time to start the IV could not be accurately determined. Also excluded were arrests where a physician was present on the scene and in medical control, and arrests where an IV could not be started.

Standard methods of statistical analysis using Chi square and student's t-test were used.

Results:

There were 123 out-of-hospital cardiac arrests during the study peirod, 70 of which met inclusion criteria for our study. Of these, 23 (33%) followed the previous protocol (base station contact prior to IV start) and served as the control group. The remaining 47 (67%) followed the current protocol (IV start on standing orders) and served as the study group.

Time to IV start was significantly shorter ($P < .03$) in the standing order group (8.9 +/-3.8 min) than the control group (10.9 +/-3.9 min). There were no significant differences between groups with respect to patient age, initial cardiac rhythm, time spent on the scene

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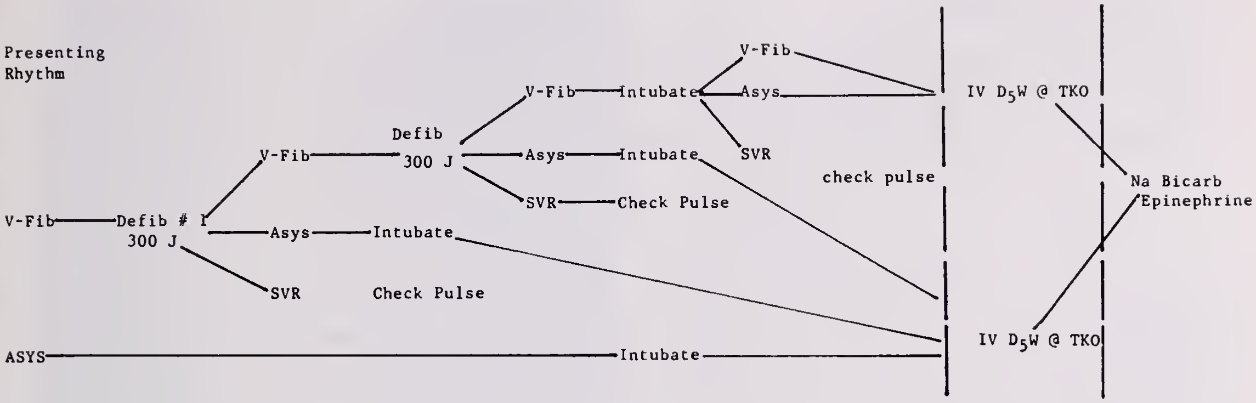
FIGURE 1: Paramedic Treatment Protocol for Cardiac Arrest.



prior to patient transport, or survival to hospital admission (table 1).

Discussion:

Although our study compares concurrent control and experimental groups, the control group was composed of runs where the newly-introduced protocol was not followed. This could have introduced bias into the study, since it could be argued that paramedics who have not assimilated the newest protocol changes may be less proficient and therefore may be less skillful at IV insertion. We think this possibility is unlikely because: 1) there was no consistency in the specific paramedic or teams of paramedics who followed the new protocol (often the same team would follow the new protocol for one arrest and the old for the next); 2) the amount of time in the field was not significantly different between the control and experimental groups; and 3) survival was not significantly different between the two groups.

Arguments against standing orders include: 1) time may be wasted by paramedics without the base station being able to intervene; and 2) paramedics may attempt to implement the order in circumstances which do not warrant use of that technique. Our results indicate that standing orders take less time to implement than radio contact orders by deferring base station contact until after the procedure is carried out. By confining our standing orders to well-defined conditions (such as cardiac arrest), we have had no instances in which paramedics have attempted to implement their orders inappropriately. Regular scheduled base station run reviews, where physicians and nurses go over each rescue call with the paramedics, have been our most effective mechanism of control.

Summary:

We conclude that standing orders to start an IV during a cardiac arrest saves approximately two minutes. Standing orders for additional steps in resuscitation or for other medical conditions may also result in quicker treatment. We feel that careful definition of the circumstances in which a standing order is to be used, regular run reviews, and continuing education of prehospital providers is the best guarantee of quality control.

TABLE 1: Comparison in Presenting Rhythm and Outcome Between the Control and Study Groups.

	CONTROLS			STUDY GROUP		
Presenting Rhythm	N	# with pulse present on arrival to Emerg Dept	Survived to hospital discharge	N	# with pulse present on arrival to Emerg Dept	Survived to hospital discharge
Asystole	9	1	0	5	1	0
V-fib/V-tach	28	7	3	11	1	1
Idioventricular	10	1	0	3	1	0
Supraventricular	0	0	0	2	2	2
Other	0	0	0	2	1	1
TOTALS	47	9	3	23	6	4

Case Report:
Posterior Tibial Arterio-Venous Fistula and False Aneurysm

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TRAUMATIC false aneurysms and arteriovenous fistulae may occur in many different anatomic locations. It is not uncommon for these two conditions to co-exist. Elkin and Shumacker found that 60 percent of those patients with arteriovenous fistulae had an associated false aneurysm.[1] A review of the literature reveals that their location in the posterior tibial artery is quite uncommon.[2] We report here a case of this problem associated with an open comminuted fracture of the tibia and fibula.

Case Report

On 3/1/83 a 24 year old male suffered a fall while working on a construction project. He sustained an open comminuted fracture of the mid-shaft of the right tibia and fibula. In addition, an undisplaced fracture of the right medial malleolus was noted on x-ray. Cutaneous and underlying soft tissues were lacerated for a length of approximately 6 cms. One portion of the laceration was impaled by the protruding shaft of the tibia. The patient was immediately transferred to the operating room, a thorough debridement was done, and the fracture was reduced. However, no internal fixation devices were inserted. No other major organ systems were noted to be injured.

The patient's post-operative course was unusual with reference to pain. He complained of severe discomfort in the area of the fracture as well as pain in the sole and heel of the affected foot. The plaster dressing was bivalved and the pain did subside somewhat; however, it continued to plague the patient throughout his hospital stay. The post-operative course was further complicated by a right lower lobe pneumonia, which resolved with antibiotics.

The patient was followed for many months. The treatment consisted of leaving the knee in extension and encouraging weight bearing with frequent checks as to alignment and healing of the fracture surfaces. No infection developed. A large area of granulation tissue gradually receeded with repeated cauterizations. Healing progressed and the plaster was removed on August 16, 1983. The patient was re-evaluated on October 6, 1983, at which time he complained of a mass over the inner aspect of his right leg.

The patient was readmitted on 10/25/83 with venous distension of the right lower leg with brawny edema and hemosiderin pigmentation of the skin over the injured area. Poor wound healing was present in the area of the previous laceration. Clean granulation tissue was present but would not heal. A 5cm pulsatile mass was present in the medial aspect of the right lower leg. In the right foot, he had no plantar flexion, poor dorsiflexion, numbness and paresthesias over the distribution of the posterior tibial nerve, and the right foot was cool. A to and fro murmur associated with a thrill was evident directly over the mass. Varicose veins were present distal to the mass. An arteriogram showed a false aneurysm and arteriovenous fistula (6.5cm X 5.7cm) in the mid portion of the calf arising from the posterior tibial artery (Fig. 1). The anterior tibial artery and peroneal branches were normal.

At the time of the operation, extensive scarring and fibrosis were present at and near the aneurysm. The posterior tibial artery distal to the mass was very small (about 1mm). It was obvious that it had been completely divided by bony fragments from the injury. These facts, plus the presence of patent anterior tibial and

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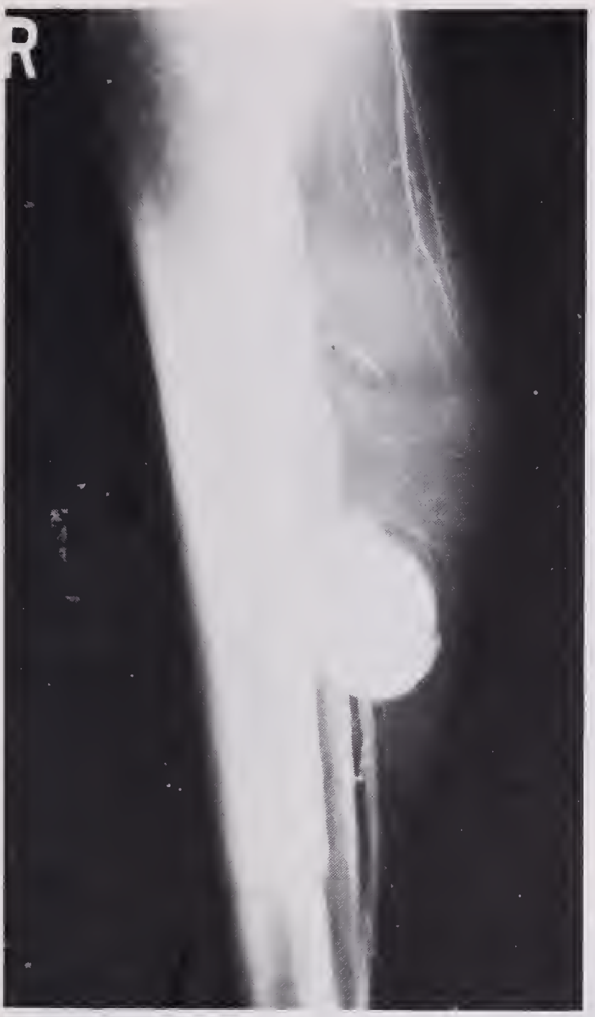

Figure 1
Arteriogram showing aneurysm of posterior tibial artery with early filling of veins.

peroneal arteries, led us to the choice of quadruple ligation as the operative treatment.

The post-operative course showed marked improvement in the condition of the leg. The previously non-healing wound healed in several weeks. The edema and venous distension completely disappeared. The mass was gone after surgery and the foot regained its warmth. He also regained full use of dorsiflexion and plantar flexion of the right foot.

Discussion

In false aneurysms, the sac is composed of only a fibrous capsule, whereas in true aneurysms, layers of the arterial wall are present. Although most false aneurysms are caused by disruption of the anastomotic suture line, they can be traumatic in origin. Arteriovenous fistulae, on the other hand, usually result from penetrating trauma. In the case presented here, the penetrating objects were bony fragments of the tibia and fibula.

A high degree of suspicion is the surest way to diagnose an arteriovenous fistula with or without a false aneurysm. Persistent swelling and pain at the fracture site or poor wound healing should raise the possibility of this problem. Peroneal palsy or paresthesias of the foot also should lead to further diagnostic tests. Unilateral varicose veins or other signs of venous hypertension are not uncommon with an arteriovenous fistula. The presence of a pulsating mass, with or without a bruit, will usually confirm the diagnosis. Once the clinical diagnosis is suspected, arteriography should be performed. This will provide permanent documentation, identify the anatomy, and supply the surgeon with information needed for the operation.

Essentially all arteriovenous fistulae should be repaired or removed. The type of treatment depends upon the size and location of the lesion. Operative repair is best done within 24 hours of the injury. Separation of the fistula with vascular repair of the artery and vein is the ideal treatment. Quadruple ligation close to the fistula can be used for small, mature fistulas involving non-dominant arteries. It should be done after collateral circulation has had a chance to develop.

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FRACTURE OF THE MONTH

Torus Fracture of the Distal Radius Producing Growth Arrest

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Case History:

THIS 11 year old female fell onto her left wrist sustaining a torus fracture of the left distal radius with no evidence of either articular or growth plate involvement (Figure 1). She was splinted for ten days until pain was relieved and then allowed to resume use of the wrist and hand. Twenty months later she was noted to have deformity of the wrist consisting of radial deviation and prominence of the distal ulna. Radiographs showed closure of the distal radial growth plate with overgrowth of the ulna (Figure 2). The purpose of this case presentation is to discuss this unusual problem with growth arrest after a seemingly minor injury to the wrist.

Discussion:

The growth plate (physis) consists of five distinct layers from the epiphyseal to the metaphyseal side (Figure 3). Closest to the bony plate of the epiphysis is the layer of resting cartilage cells, (1) followed in order by the layers of proliferating cartilage, (2) hypertrophied cartilage, (3) degenerating cartilage (4) and an area of bone formation at the metaphyseal side (5).[1, 3]

The blood supply to the growth plate comes from both epiphyseal and metaphyseal circulation. The major nourishment for the growth of the growth plate however, comes entirely

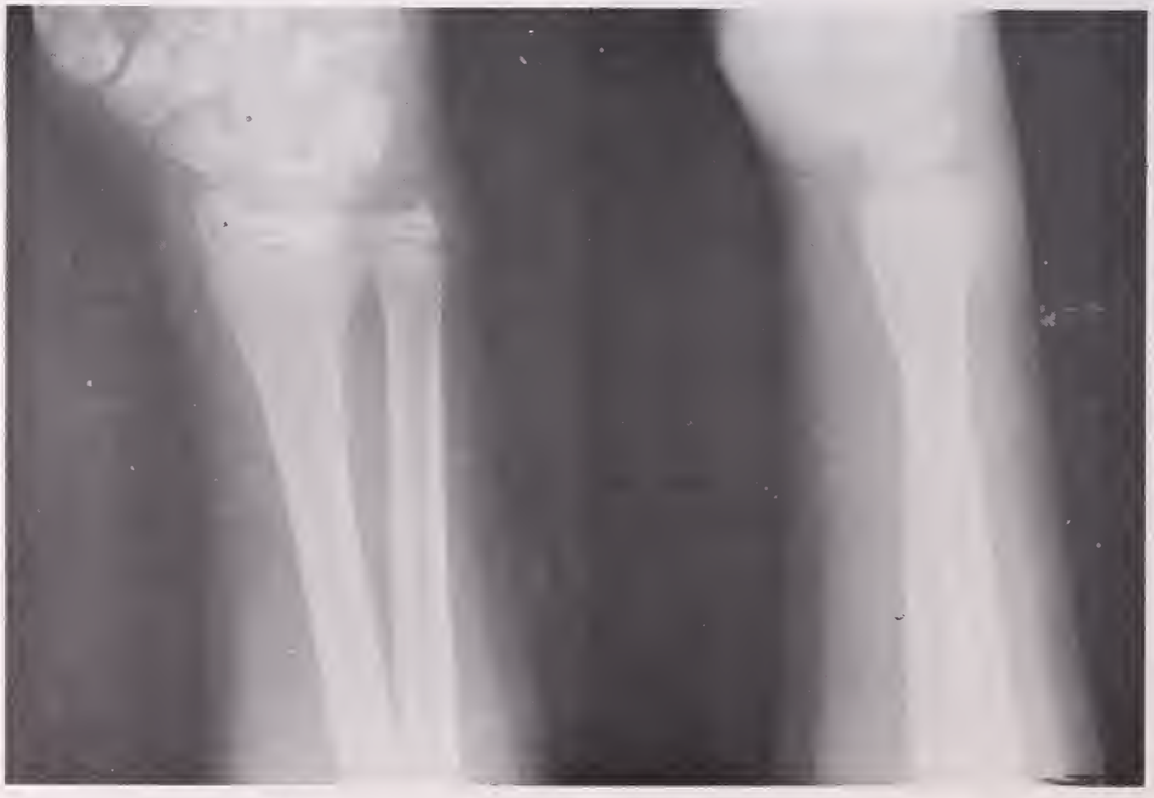

Figure 1: Initial radiographs showing a minimal torus fracture of the distal radius.

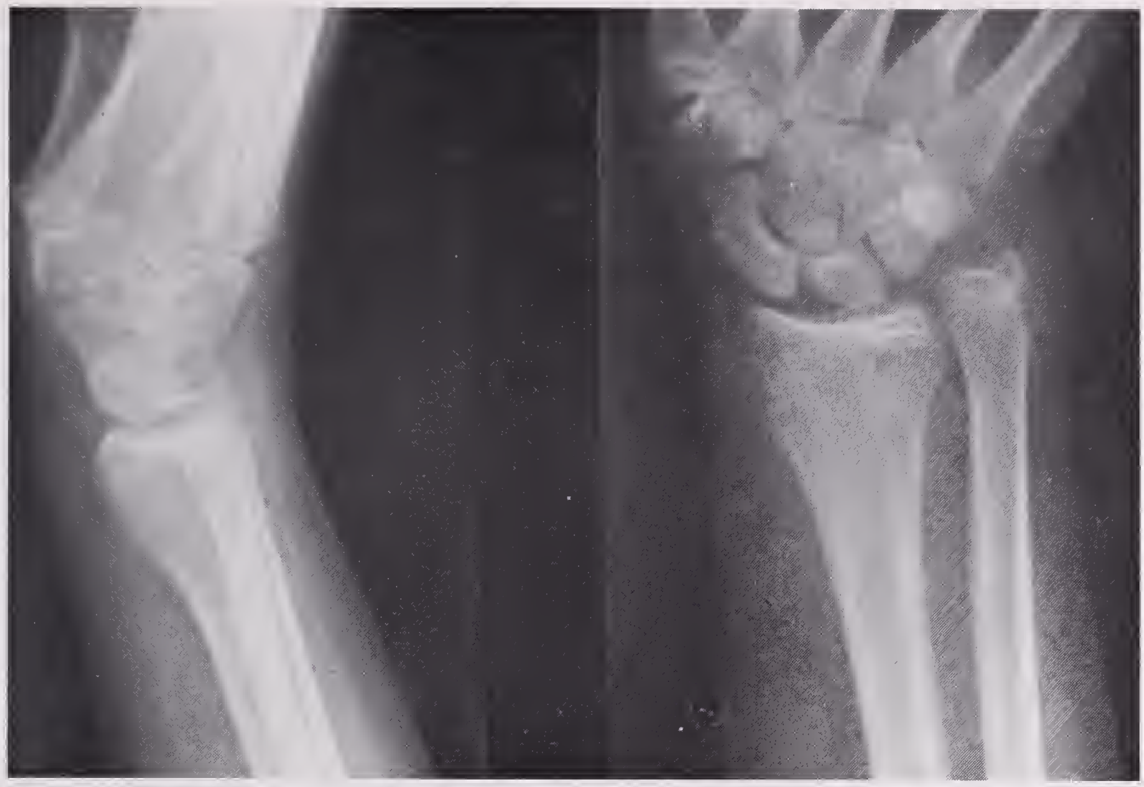

Figure 2: Twenty months post injury. The radial growth plate is closed while the ulna continues to grow. This caused the visible deformity.

from the epiphyseal side. On the metaphyseal side the blood vessels branch off from the nutrient artery and then penetrate into the area of degenerating cartilage cells. (6) This process converts the cartilage septa into bony trabeculae.[2, 3, 4]

Normally the epiphyseal and metaphyseal circulatory systems remain separated by the growth plate until the growth center closes at skeletal maturity. Premature joining of these two circulatory systems, with their osteoprogenitor cells, leads to a bone bridge forming across the growth plate and early growth arrest. (Figure 4)

Early closure of the growth plate may also occur if circulation from the epiphyseal side becomes occluded, thereby impairing nourishment to the immature cells in the growth plate. Partial closure of the growth plate leads to asymmetric growth with consequent angulation of the bone. That portion of the growth plate which remains open continues to grow and leads to either a varus or valgus angulation.[3]

In this particular case, blunt trauma apparently affected epiphyseal circulation sufficient-

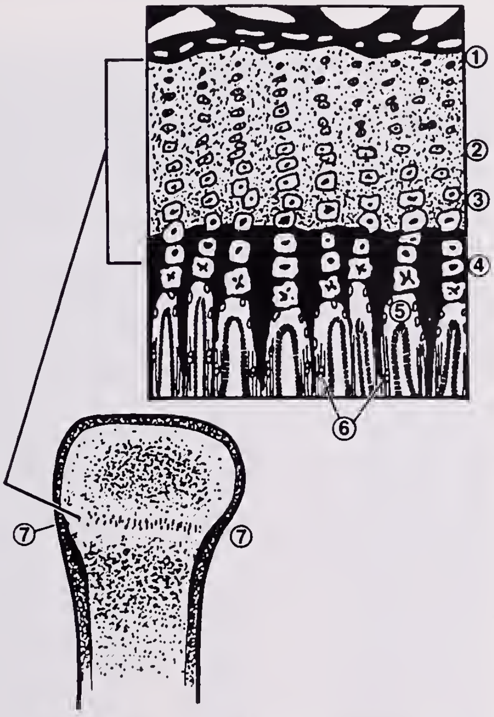

Figure 3: Zone of 1) resting cartilage, 2) proliferation, 3) hypertrophy, 4) degeneration and calcification, 5) bone lattice formation, 6) ossification, 7) growth plate. (From Connolly, JF: The Management of Fractures and Dislocations, 3rd Edition, W.B. Saunders, 1981, p. 146.

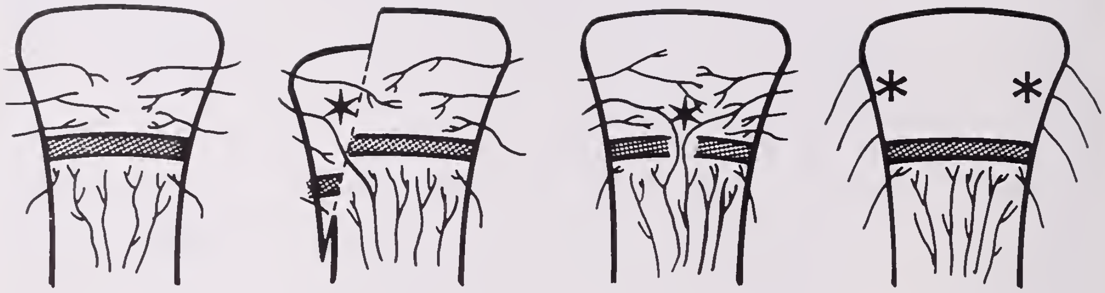

Figure 4: Star indicates communication of epiphyseal and metaphyseal circulation; and epiphyseal vessel damage. (From Shapiro, Frederick: Epiphyseal Growth Plate Fracture-Separations. A Pathophysiologic Approach. Orthopaedics, 5:721, 1982)

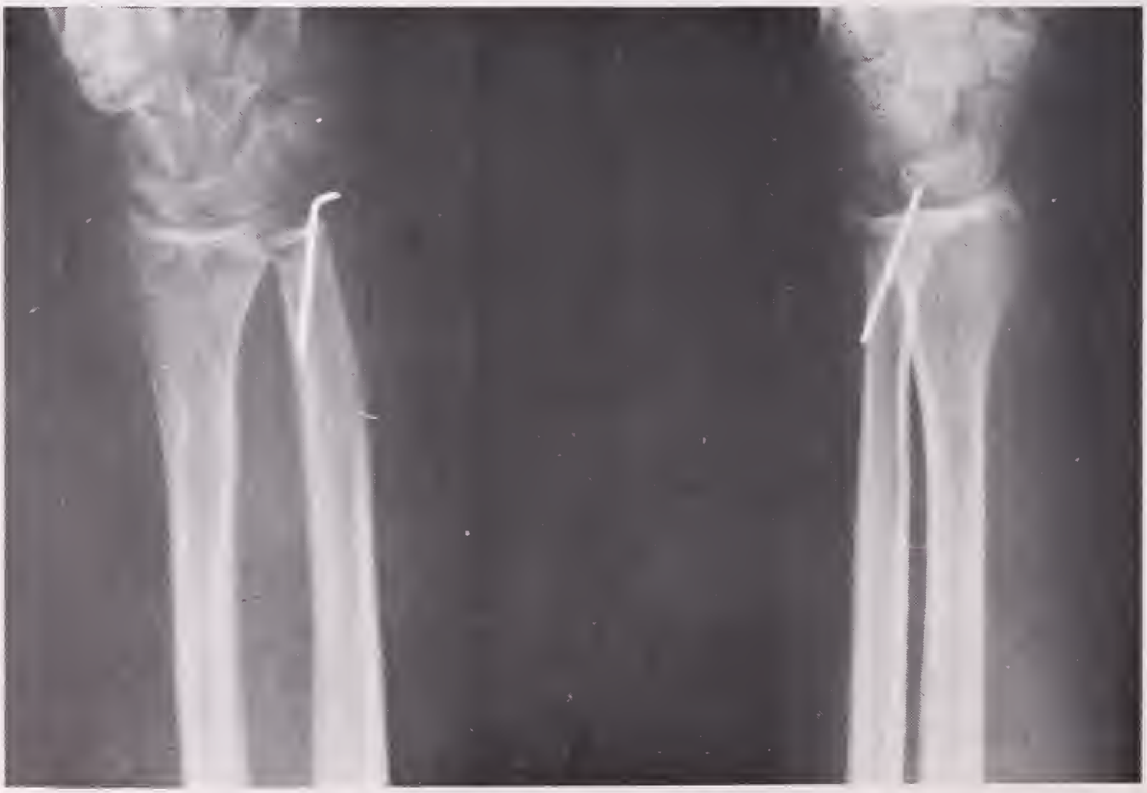

Figure 5: Postoperative radiograph after osteotomy of the ulna and epiphyseodesis.

ly to halt growth of the entire radial plate. The ulna epiphyseal growth plate, however, remained open and continued to grow thereby causing the ulnar prominence and radial deviation of the wrist, which was the patient's chief complaint 20 months after injury.

Management:

At age 13, the distal ulnar growth plate was closed and the ulna shortened to correct the prominence of the distal ulna and prevent the increasing deformity. This was done by resecting five millimeters of distal ulna including the growth plate (Figure 5). The wrist was then held in plaster for six weeks after which range of motion was allowed.

At latest follow-up, 2 years, 3 months postoperatively, the patient had full function of the wrist, no deformity, and was asymptomatic in the wrist. X-rays showed no change in the relationship of the carpus, radius and ulna.

This patient represents a good example of the problems which can sometimes follow apparent minor injuries in the skeletally immature patient. The control mechanisms of growth are usually quite efficient. However, keep in mind that injury of any kind can sometimes alter the delicate balance of growth and lead to symptomatic growth deformity.

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MEMORIES OF MEDICINE

The Pleasant Career of a Busy Ob-Gyn

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THIS manuscript is a report of a 44-year obstetrical and gynecological career. The manuscript begins at a time when there were no antibiotics. Medical research was well on the way of having sulfa, the first "miracle drug" ready for the public. We were taught to practice clean medicine and, by all means, to avoid a serious infection.

The report is divided into four groups of approximately ten years or more. In each of the decades, there has been an improvement of the fetal and maternal mortality over the previous decade. This trend has ended up with a very low fetal mortality in the fourth decade. (TABLE I)

Each dedicated physician has had some incentive leading him into the field of healing. My father had a cattle herd, but also some grain and hay production in Butler County, Kansas. I was anxious to help my father when treating cattle, horses, and mules. This included treating the sick, suturing wounds, vaccinating, castrating, dehorning, and branding. I was taught some important principles in castrating and dehorning which, if observed, greatly reduced bleeding and infection. I was also taught that one has only one chance at an operation, so it was necessary to do it right the first time. This was all excellent training.

TABLE I FETAL DEATHS RELATED TO ABNORMALITIES OR PRESENTATION AND GESTATION

	10-31-36 to 12-31-47 11 yrs., 2 mo. 1042		1-1-48 to 12-31-57 10 yrs. 6145		1-1-58 to 12-31-67 10 yrs. 7495		1-1-68 to 9-14-80 12 yrs., 9 mo. 3792	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
Premature	9	0.86	53	0.86	45	0.60	5	0.13
Cerebral injury	5	0.47	6	0.097	5	0.066	0	0
Cord Death either knot or prolapse	0	0	5	0.081	3	0.04	0	0
Asphyxia	1	0.095	0	0	0	0	0	0
Malformation	5	0.47	19	0.31	21	0.28	6	0.16
Placenta abruptio	3	0.28	30	0.49	9	0.12	2	0.053
Placenta previa	1	0.095	6	0.09	2	0.026	2	0.053
Intestinal obstruction	0	0	1	0.016	1	0.013	0	0
Pneumonia	3	0.28	6	0.096	6	0.080	1	0.026
Twins	0	0	0	0	0	0	0	0
Premature	4	0.38	9	0.15	15	0.20	7	
Ruptured Uterus	0	0	0	0	1	0.013	0	0
Breech	1	0.095	8	0.13	9	0.12	0	0
Triplet Premature	0	0	1	0.032	0	0	0	0
Toxemia	3	0.28	6	0.09	3	0.04	0	0
Diabetis	0	0	2	0.032	2	0.026	2	0.057
Meningitis	0	0	0	0	1	0.013	0	0
Erythroblastosis	2	0.19	19	0.31	14	0.19	1	0.053
Disproportion	1	0.095	0	0	0	0	0	0
Craniotomy	2	0.19	0	0	0	0	1	0.026
	40	0.038%	171	0.028%	137	0.018%	27	0.007%

My medical education was at Kansas University, where all though our clinical years it was emphasized to make certain of making a correct diagnosis. On being assigned a patient, it was necessary to make every effort to find out "what is wrong" before recommending treatment. We did a hemoglobin, but all other lab information was withheld; our diagnosis was done on the history and physical.

My obstetrical training was at Chicago Lying-In Hospital under Dr. Joseph B. DeLee. My gynecological training was at Chicago Rush Presbyterial Hospital under Dr. Sproat Heaney. The value of instruction by such capable professors cannot be measured by ordinary standards, because it prepares one to deal with such a wide variety of complications and circumstances.

The excellent facilities in hospitals, the care of prematures, the wide variety of laboratory procedures are all factors that make American medicine great. This is very beneficial to all patients, and a great asset to the obstetrician. My first goal was to give excellent care to the expectant mother. This created a very rewarding life, because it was a life of service. Each patient was made to feel that she was considered someone special. So, regardless of economic or social status, color or creed, all had the assurance of my total attention. I would ask about any problems or disagreeable feeling as soon as I entered the room. After examination, I would assure her that the baby was fine and inform the mother of her condition. The mother was instructed about diet, limiting weight gain, swelling, and any complications which we hopefully would detect in the early stages.

My goal was never to deliver a record number of babies, and the above principles brought in a large number of patients. The total number of babies I delivered was 18,475. I am a very ordinary person, but I can testify that the Lord gave me unusual stamina.

One necessity is to keep complete and accurate records. The date of procedures, the dosage of medication, date prescribed, date discontinued, and good or adverse effects must all be accurately recorded. Some of our records have appeared in court, where clearness and accuracy cannot be overemphasized. One of my professors gave this very wise counsel: "Sweep your decks clean every night." William James stated: "Nothing is so fatiguing as the eternal hanging on of an uncompleted task." Having our decks clean avoids stress, one great hazard of a physician.

I preferred to have prenatal care start in the early nausea and vomiting stage which, if untreated, rapidly becomes worse. Weight gain must be controlled from the very beginning. Toxemia and pre-eclampsia are preceded by too much weight gain, albumin in the urine and a slight elevation of blood pressure, especially the diastolic, all of which are early warning signs. To keep the mother doing well, a close check of all these details is absolutely necessary.

One simple, but effective method is to start with a two-hour rest period several times a day, lying down and elevating the feet. More rest is prescribed when needed. A diuretic is given which will reduce swelling, increase urinary output and, along with this, comes a lowering of the blood pressure.

Diabetes is a serious complication. To me, it was important to have a very capable internist to take control of the diabetes. Pregnancy adds to the instability of the blood sugar. With good diabetic control, the pregnancy usually goes very smoothly. Sometimes, a few days' hospitalization are very beneficial to impress the value of following instructions. The same applies to the toxemia patient not following the program prescribed for her when at home. In either diabetes or toxemia not well controlled, the baby may suddenly stop moving and be stillborn. So, keep ahead of trouble.

Every mother would be pleased to have a comfortable pregnancy so, at the first visit, limiting her weight was emphasized. Mothers with essential hypertension require close attention from the first visit on. The mother with nephritis is a risk before pregnancy and now an extra burden increases her hazard. Both the nephritic and the diabetic could be a bomb ready to explode. They both have a great yearning to have a baby and are very elated to find themselves pregnant. I welcomed these patients, instructing them about danger signals, and advised them to report any change of condition. If warning signals appear, a stillborn baby is a possibility. An early induction is preferable if, in the judgment of the obstetrician, the baby is in danger. Such patients usually have a short labor, the baby is thin and more mature than its weight would indicate, so the outcome has a good chance of turning out to be a normal premature baby.

The obstetrician has a great obligation to four groups of people who are very unfortunate in their own eyes: 1) the couple who have a spontaneous abortion the first three months; 2) the couple who has a spontaneous late abortion in the second trimester; 3) the couple whose pregnancy goes into the third trimester, ending in a premature labor with the baby too premature to survive; and 4) the infertile couple who has been unable to get a pregnancy started. Any couple where the wife is overdue on a menstrual period of 10 to 14 days will assume there is a pregnancy; this can be confirmed by a pregnancy test. Nausea and vomiting may also start quite early. Nausea and vomiting give evidence that the corpus luteum is secreting considerable amounts of hormone, and such a pregnancy carries itself quite well. If there is a deficient secretion of hormone, the mother may notice vaginal spotting. Spotting or bleeding is abnormal and needs to be treated, because it will soon be followed by cramps. Cramps must be stopped at once by bed rest and sedation given frequently enough to stop the cramps. I have found hormone tablets very useful to add to bed rest and sedation if the cramps are not subsiding. I used small doses of both estrogen and progesterone. Synestrol is a synthetic estrogen and Enovid is a progesterone. I would start Synestrol 10 mg t.i.d. and, if spotting had not completely stopped in 24 hours, I would add Enovid 10 mg b.i.d. They were increased as indicated.

Someone who has had a previous abortion welcomes all the help she can get to assure a live, healthy baby. The couple who has had the heartbreaking experience of losing a pregnancy in the second trimester, when hopes are built up, will need immediate attention if cramps or bleeding begins by ordering bed rest and sedation, or even hospitalization where deeper sedation can be given. The couple who has lost pregnancies in the last trimester, with the baby born alive but too premature to survive, will be eternally grateful to have a pregnancy go to near enough term with a normal, healthy baby. I had patients come to me who had up to seven pregnancies ending in failure. I always gave sedation enough to decrease the apprehension. Fear is a great enemy of anyone threatening to lose a pregnancy, because fear will intensify the cramps greatly, so these mothers must have sedation tablets in their home or, if contractions do not stop, she must be hospitalized.

Each obstetrician must deal with serious complications such as toxemia, abnormal presentations, including breech, persistent occiput posterior, transverse lie, relative cephalopelvic disproportion with high station, and multiple pregnancy. Any one of these complications may sometimes prove fatal for mother or fetus. Therefore, the close observation and constant care of the pregnant mother is absolutely necessary.

There are certain unforeseen factors which, in the process of human reproduction, suddenly are upon us and must be accepted and adjusted to. These are malformations, prolapsed cord, placenta previa, placenta abruptio, erythroblastosis fetalis, cerebral injury, asphyxia, meningitis, fetal pneumonia at birth, maternal diabetic coma and surprise multiple pregnancy.

In 1958 an instructor in muscle relaxation came to teach physicians. He made a circuit of ten cities, coming to Lincoln every two weeks for a total of 14 sessions. I was very interested in the course because I wished to be better able to help my mothers relax their muscles when they were nervous and tense. Many mothers on entering the hospital had great fears and were under much stress. Such mothers had tense muscles and were putting themselves at great disadvantage which prolonged their labor. When word got around that there was something to relax their muscles, calm fears and hopefully shorten the labor, it came as a welcome solution.

For conditioning I had a one hour relaxation class once a week. It required less than five minutes to help a mother relax her muscles. The cue for relaxation was putting a hand firmly on the left shoulder. The relaxation could be started by myself, the nurse or the husband. I had relaxation records in my own voice which the nurses played for the patient. Relaxation had two important benefits: the labor contractions were less painful and the labor was shortened because the muscles of the cervis were relaxed. The husband would assist in the delivery room; he was at the head of the delivery table, properly gowned so he could help his wife; both could see the baby born. La Maze classes did not become available until about twelve years later. This was also a great addition to the mother's comfort.

Caesarean delivery may be done because of cephalopelvic disproportion,but may be of an emergency nature such as hemorrhage, fetal distress or abnormal presentation. I did all low cervical operations. When such mothers came for repeat delivery, I was convinced as early as 1950 that these mothers were at no risk for vaginal delivery at a later pregnancy if they were making good progress in their labor. If progress came to a standstill, or labor was prolonged, I would do a repeat Caesarean at once. My low cervical scar was found strong on every patient.

I did all of my Caesarean deliveries under local anesthesia. It had many advantages: the baby breathed spontaneously and cried lustily as soon as it came through the incision; the mother was completely awake and aware of everything; and the husband could be in surgery with her, by being properly gowned. The recovery was greatly accelerated, so the mother could be up that same day. The course was usually afebrile, certainly a great advantage.

I made an effort to keep the mother well-informed during the pregnancy, through the labor and in the postpartum days. During labor, the family appreciates being well-informed on the progress of labor; give a conservative estimate when the baby will arrive, but allow a little slack. All will be overjoyed if the baby comes sooner than estimated, and give the mother credit for it!

I did a version and extraction on every transverse lie when the cervix was sufficiently dilated for delivery of the head. I delivered face and brow presentations vaginally by natural descent but, if descent became delayed, I would delivery by version and extraction if the pelvis was adequate.

If progress stopped at 6 to 7 cm dilation, I would incise the cervix at 10, 2 and 6 o'clock, permitting the presenting part to descend, thus bringing a long labor to an end. The cervix is quickly and easily repaired, and the mother sent to the recovery room. Sometimes the head presents occiput posterior with no progress. Special Kielland forceps are applied, then the handles are swept around an 180° arc and a nice, healthy baby delivered. No injury to baby and mother results if carefully and gently done.

Very early, I learned that it was necessary to completely empty the uterus after delivery. I gave I.V. Pitocin when the anterior shoulder was delivered, then waited 30 seconds before completing the delivery. The contracting uterus shears off the placenta. One sees that the baby is breathing well, then turns around to deliver the placenta, which is usually right there. In every case, I would explore the uterus to be sure it was clean and to remove any cotyledon if one had remained attached. This eliminated a second trip to the delivery room for hemorrhage. I used only relaxation for uterine exploration, a procedure very easily tolerated.

Fetal mortality is an indication of the quality of care by the physician, nurses and the facilities of the hospital. I am thankful that the Lord has kept His hand over me with an improvement in fetal mortality in each decade. I am contrasting my series with that of Nebraska Board of Health, which shows improvements in fetal mortality in each decade. (TABLE II).

A famous general, when asked about his success, answered that the first step is to surround yourself with capable lieutenants. My entire office staff was always cooperative, with each one performing their task in a very commendable way. The same thing can be said about the OB force of each hospital. Special mention must be made of the OB force at St. Elizabeth Hospital, where the largest percent of these babies were born. A tribute goes to Sister Francesca, head OB nurse, who many times worked untiring long hours, being busy in the delivery room, or would be found in the nursery specialing a premature baby.

A well-informed office staff is very important for the mother's total well-being. First, any abnormality which was a vital change needed to be detected. At any regular office visit, when weight, blood pressure, urine analysis were outside of normal range and increased swelling was noted, it was brought to my attention at once. I had such a reliable office staff, who knew the danger signals. Such an office staff adds so much to the safety of mother and baby, but also to the good results of the obstetrician. Such a reliable staff keeps the patient flow moving smoothly, and it also keeps accurate books so that accounts were collected well. Such a staff is a rare treasure.

An associate shared office space, each one having their own OB patients, but assisting each other with Gyn surgery and assisting each other in all obstetrical operations. M. John Epp, M.D. was my associate in this way from 1956 to 1969. It is with high respect that I regard this friendly and pleasant association with this fine gentleman.

From 1970 on, Dr. J. W. Ballew exchanged operative assistance in surgery with me. We scheduled all our major surgery for 7:45 a.m. We were in separate offices, completley unrelated in this respect. We would schedule minor surgery after completing our major operation, each one working alone for that. This exchange of work was also a congenial relationship, with excellent cooperation of all concerned.

The infertile couple is an unfortunate group. Such a couple sees brothers, sisters and friends all having babies and showing them off, while nothing is happening at their home. One usually has no trouble getting good cooperation from this couple, especially the wife. The husband may be reluctant to submit to having a semen examination because, if he is the infertile one, he would not want it known. The wife will proceed with any necessary examinations to test for tubal patency and also for studies to indicate ovarian function. She needs a thorough pelvic and complete physical examination. Any health problem needs to be corrected.

Thyroid deficiency interferes with pregnancy, so I prescribe it so that their metabolism is on the positive side. Masculinity in a female needs thyroid until ovulation is established in a regular cycle. For infertility, a good method is one Clomid tablet daily from day five to nine; then start Enovid 10 mg progesterone daily, beginning day twelve for eight days; on day 28, repeat this cycle. Any month they are 12 days late, check a pregnancy test. Do not overlook thyroid in infertility; it is effective.

The infertile husband always has some motility, but too slow to progress across the field. There are almost always some sperm, even though the count may be very low. I used Depotestosterone I.M. 10 mg, which is a very practical medication, with frequency of one per month, so the husband will go along with one shot a month. A repeat check in three months will be encouraging by some improvement, either in the count or in motility. Metabolism is also a great factor. If at all indicated, some thyroid needs to be given. Adequate thyroid will improve the motility. Any of these

TABLE II. INFANT MORTALITY PER 1,000 BIRTHS

	Samuel T. Thierstein Series			Nebraska Board of Health Series		
	Live Births	Infant Deaths	Percent	Live Births	Infant Deaths	Percent
1936-1947	1,042	36	0.0345%	292,920	10,086	0.0344%
1948-1957	6,145	136	0.0221%	329,018	7,899	0.0240%
1958-1967	7,495	102	0.0136%	310,841	6,815	0.0219%
1968-1980	3,793	12	0.0032%	321,580	4,899	0.0152%
1981-1983	Discontinued OB			80,372	795	0.0099%
Totals 1936-1983	18,475	286	0.0155%	1,334,731	30,494	0.0228%

medications are sometimes the turning point to success in both wife or husband. If there is not sufficient response, I recommended donor sperm, which is a very acceptable solution to most couples; but it must be completley confidential by the couple and the obstetrician. It is so important that no one else knows.

Another solution for the infertile couple, when their efforts have failed, is adoption. The obstetrician can be of valuable assistance to such a couple by encouraging them to consider adoption and in suggesting places to go. It is so encouraging to a couple, but absolutely essential, if the obstetrician has genuine interest in being helpful.

Whenever a mother dies, it brings out the tragic side of medicine. I lost two mothers during my career. In 1943, during my OB training years, I had a home delivery at Chicago Maternity Center. This multipara had a partial placenta previa with hemorrhaging before and after delivery. A more experienced resident would have rushed her to a hospital at once. I started I.V. fluids at once, but this was not sufficient. This mother's bleeding was too rapid; she went into shock and died as an ambulance and blood arrived. This was an obstetric death.

The other mother had a very normal pregnancy up to 34 weeks gestation. She became ill and was hospitalized with chills and temperature of 104.4° with pain in RLQ and in right kidney area. She was seen by our finest internists and was given antibiotics. The urinary output decreased, but it resumed again. She became quite jaundiced by 36 weeks gestation. At this time, she suddenly went into labor of four hours, delivering a healthy male, weight 6 pounds, 7 ounces. In the five days after delivery, she continued to lose ground in spite of the best consultation and the best treatment. On day five after delivery, she expired. Autopsy revealed "acute pancreatitis." This was ruled a non-obstetrical death by the Maternal Mortality Committee. (TABLE III).

Previous to 1936, contraceptives were not available to most families, resulting in an even higher maternal death rate than found in Table III.

Doctors of medicine have always had a prominent place in human affairs. The physician is something more than one for diagnosing disease, prescribing medicine, or doing surgery. The sympathetic ear of the kind physician can do much to bring peace to the troubled soul. Also, there is healing in the physician's touch. A Doctor of Medicine degree is a special honor; therefore, a physician's greatest obligation is to "Go about doing good."

TABLE III. MATERNAL MORTALITY PER 100,000 LIVE BIRTHS

	Samuel T. Thierstein Series			Nebraska Board of Health Series		
	Live Births	Maternal Deaths	Percent	Live Births	Maternal Deaths	Percent
1936-1947	1,042	1	0.0010%	292,920	711	0.0024%
1948-1957	6,145	0	0%	329,018	174	0.0005%
1958-1967	7,495	0	0%	310,841	64	0.0002%
1968-1980	3,793	0	0%	321,580	39	0.0001%
1981-1983	Discontinued OB			80,372	3	0.00004%
Totals 1936-1983	18,475	1	0.00005%	1,334,731	991	0.0007%

President's Page

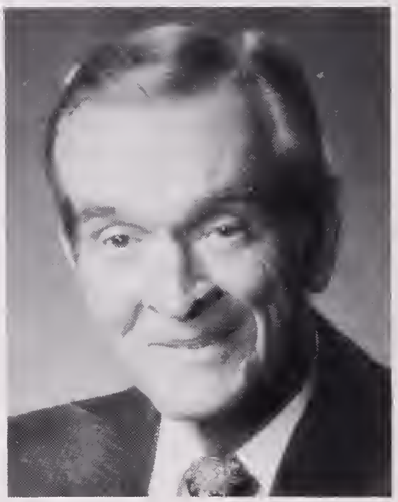
ADJUSTING AFTER TRANSITION

This past year has been aptly labelled **Medicine In Transition** by Doctor Reese. This period now continues as we are not sure where all the pieces fit but as we observe the rapid changes taking place it becomes clear we are not only faced with a drastic transition but also a formidable task of adjustment. The era starting with the end of World War II is now coming to a close and we are moving into a new one that has the potential of producing disasterous effects on the entire Health Care Industry.

These changes made in the name of badly needed cost control are attempting to achieve this goal by reducing accessibility of health care, rationing medical aid, and placing the entire medical industry in the hands of so called delivery systems and corporations whose sole aim is making a profit by reducing the access to health care. With the impact of monetarization of the industry, particularly hospitals, there is deep concern about the growing conflict between medical ethics and money making goals. To view the practice of medicine as just another business undertaking like retailing or banking is blind to the activity and role of a professional. If we don't protect and preserve our standards, no other groups would or could be capable of doing it. The task of making a satisfactory adjustment will not be easy in spite of the fact we are accustomed to ever changing aspects of clinical medicine. Adjusting to the changes in the socio-economic changes will be formidable.

The words of William Jennings Bryan in a speech made 85 years ago in Washington are loaded with meaning for us today.

"Destiny is not a matter of chance; it is a choice, it is a thing to be achieved." Our destiny should be preservation of the availability and quality of medical care, retaining our role of the advocates of the sick, strengthening relations with not only ourselves but our hospitals and never allow our ethical or professional standards to be diluted.


Francis D. Donahue, M.D.

From those going before us, we have inherited the professional legacy they left and if we are to pass this on to those following, we must make adjustments that will demand courage and constant vigilance. If we fail we will have forsaken our heritage and abandoned our calling. Destiny is certainly a choice, not a chance. Each physician will find his circumstances different and make adjustments accordingly with help from organized medicine. We must rivet our every thought and act to that objective that has been our pole star through the ages, the quality of medicine. When that ceases to be the goal of medicine we have destroyed the sacred covenant between physician and patient. There are those who would market medicine like hamburgers and urge us to join them and once that is accomplished our profession as we know it is gone.

The past and present eras meet in an evanescent present and in our confines one door must be opened and closed to let in the good parts of the past and keep out the undesirable. Another door must be opened to provide access to the future and at the same time closed to prevent progress along improper paths.

The thought of living in a cubicle with swinging doors brings to mind the sentiment expressed in the Rubaiyat of Omar Khayam.

"As I think of the past and places I've been
I've often came out by the door I went in."

Francis D. Donahue, M.D.

The Auxiliary

Nebraska Medical Association Auxiliary Annual State Convention Meeting April 26-28, 1985

Report: Resolutions Committee

WHEREAS, we consider it fitting and proper to express our thanks to all who have contributed to the success of the Convention and the accomplishments of our past year, therefore be it

RESOLVED, that we, the members of the Nebraska Medical Association Auxiliary, extend our grateful thanks and appreciation to the officers and other members of the Nebraska Medical Association Auxiliary Executive Board who have so ably carried on the business necessary for the proper functioning of our organization; and be it further

RESOLVED, that our thanks and appreciation be specified to the members of the Lancaster County Auxiliary, hostess to this sixtieth annual meeting, for the gracious hospitality extended to all of us; and be it further

RESOLVED, that we are expressly grateful that Mrs. Wayne C. Brady, president of the National American Medical Auxiliary, found it possible to meet with us on this, our sixtieth year of existence; and be it further

RESOLVED, that we declare particular gratitude to the president of Lancaster County Auxiliary, Desta Osborne, and her Convention Chairmen, Joyce Urbauer and Elba Lau and their capable helpers who thoughtfully planned for our entertainment and pleasure, and be it further

RESOLVED, that the Nebraska Medical Association be advised that we appreciate their assistance and leadership, that in particular our thanks go to Doctor Herbert Reese, President of the Nebraska Medical Association, and to his Commission on Association Affairs, that they be informed of our gratefulness for their help and advice throughout the year, specifically for including us in the dinner meeting with the Nebraska State Senators, and in sharing with us those portions of their program we are privileged to attend, and be it further

RESOLVED, that a vote of confidence be expressed to Doctor Jerald Schenken with best wishes from the NMAA for a successful campaign in being elected to the AMA Board of Trustees, and be it further

RESOLVED, that Doctor Alan Forker, Editor of the Nebraska Medical Journal, Mrs. John McGreer III, Editor of the Newsletter, Nebraska Medical Liability Mutual for their interest and monetary support of our Newsletter, Mr. Kenneth Neff, Executive Secretary of the Nebraska Medical Association, Mr. William Schellpeper, Assistant Executive Secretary, and to the State Medical Office personnel for their help in preparing materials and mailing the Newsletter, be apprised of our sincere thanks for the efficient way they handle our Auxiliary news, for their ready assistance whenever we ask for it, and be it further

RESOLVED, that we pledge our loyalty and devotion to the Nebraska Medical Association Auxiliary; that we continue to be faithful in supporting its activities, promoting its projects and protecting its reputation and high ideals, and be it finally

RESOLVED, that these resolutions be published in the NEBRASKA MEDICAL JOURNAL.

Respectfully submitted,

Mrs. Fay Smith
Resolutions Chairman

Welcome New Members

Margaret K. Stockwell, M.D.
Gordon, NE 69343

N. Kenneth Furlong, M.D.
601 N. 30th
Omaha, NE 68131

Frederick P. Ogren, M.D.
UNMC - 42nd & Dewey Ave.
Omaha, NE 68105

Steven E. Shefte, M.D.
247 Doctors Bldg., N. Tower
Omaha, NE 68131

In Memoriam

> *By medicine life may be prolong'd*
> *yet death*
>
> *Will seize the doctor too.*
>
> *—Shakespeare*

Allan J. Hruby, M.D. — (Born September 1, 1918 — died March 21, 1985) — Medical Specialty — General Practice. Doctor Hruby was a graduate of the Chicago Medical School in 1943. He was a member of the Nebraska Medical Association and the American Medical Association. Besides his wife, Elizabeth, survivors include a son, Allan III of Eureka, CA; a daughter, Lynn Aramian of North Andover, MA; and a sister, Jean Langworthy of Libertyville, IL.

Elroy Brugh, M.D. — (Born in 1922 - died March 22, 1985) — Medical Specialty — General Practice. Doctor Brugh was a graduate of the University of Nebraska College of Medicine in 1947. He was a member of the Nebraska Medical Association and the American Medical Association.

Coming Meetings

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

NEBRASKA STATE SOCIETY OF AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, North Central Regional Conference — June 28, 29, 30, 1985, Lincoln Hilton Hotel, 141 North 9 Street, Lincoln, NE 68501. Registration deadline: June 7, 1985. Fee: $65. Contact: Linda Koch, CMA, Family Practice Program, 4600 Valley Road, Lincoln, NE 68510, Phone 402-483-4591.

TETON'S GENERAL PEDIATRIC CONFERENCE — June 30 - July 6, 1985. Sponsor: Department of Pediatrics, University of Nebraska College of Medicine. Location: Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 20 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Pediatric cardiology, gasteronterology, genetics, asthma, allergies and immunology, neonatology, nutrition and eating disorders. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

TETON'S SPORTS MEDICINE CONFERENCE — July 7-11, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: Conference Center, Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 16 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Current concepts on evaluation, conditioning, management and rehabilitation of the recreational and competitive athlete as well as use of exercise therapy in a variety of medical problems and injuries. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

LAKE OKOBOJI SPORTS MEDICINE CONFERENCE, "THE YOUNG ATHLETE" — July 24-27, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: The New Inn Conference Center, The New Inn Lodge, Okoboji, Iowa. Credit: 12½ Hours AMA Category I and AAFP Prescribed. Fee: $150 physicians, $75 residents in training & students. Topics: Identification and management of sports related injuries, current concepts on nutrition and the care of the young athlete with medical problems. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, Nebraska 68105. (402) 559-4152.

EMERGENCY MEDICINE REVIEW — September 23-28, 1985 and will be repeated on October 1-12, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. Credit: 45 hours AMA Category I, AAFP Prescribed & ACEP Category I. Fee: $425 physicians, $325 residents in training. Content: This course will provide physicians engaged in the evaluation and treatment of urgent and life threatening conditions with an in-depth review of emergency medicine. Special attention will be given to the recognition of conditions that must be identified immediately, and evaluation of nonemergency conditions. Daily national board type exams will be given. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — June 13-14, 1985. University of Kansas Medical Center. Location: Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA. Fees: $625.

ANTIBIOTIC UPDATE: CARBAPENEMS — August 14, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

HEART AND MIND: NEUROCARDIOLOGY UPDATE — September 7, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

ANNUAL SURGERY SYMPOSIUM — September 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

KANSAS CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS MEETING — September 14-15, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — September 19-20, 1985, November 14-15, 1985. Sponsor: University of Kansas Medical Center, Department of Otorhinolaryngology. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA Category I. Fees: $625. Maximum Enrollment: 9 persons per session.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

2ND MIDWEST REGIONAL CONFERENCE ON WOMEN IN MEDICINE — September 27, 28, and 29, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri. Credit: 8 hrs. AMA Category I, 8 hrs. AAFP. Fees: $130 Physicians, $60 Other Health Professionals, $20 Students. Guest Speaker: Ellen L. Shulman, M.D., NASA, Lyndon B. Johnson Space Center, Houston, Texas.

ANNUAL INTERNAL MEDICINE SYMPOSIUM — October 9, 10, 11, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

ALASKA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION — June 5-8, 1985 in Haines, Alaska. Registration should be sent in care of: Alaska State Medical Association, 4107 Laurel Street, Suite 1, Anchorage, Alaska 99508, (907) 562-2662.

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WashingtoNotes

(Continued from page 14A)

The Aging Committee report also noted that "coronary artery bypass surgery on older men has increased faster than any other type of surgery, rising 1,000% between 1971 and 1978." And several witnesses, including Kusserow, Dr. McCarthy and Harvard researcher and cardiologist Thomas B. Graboys, M.D., suggested that addition of coronary bypass to the list of procedures for which second opinions are required would substantially increase savings.

* * *

Senate Budget Resolution

A fiscal 1986 budget resolution, which could come up for a Senate vote by mid-April, calls for Medicare cuts of about $3 billion in fiscal 1986 and leaves room for reducing the impact of President Reagan's proposed freeze on Medicare physician fees somewhat. It assumes that all federal funding for health professions education will be eliminated.

The resolution, approved by the Senate Budget Committee in mid-March, still must be approved by the full Senate and any differences with a still-undeveloped House budget resolution resolved. It sets overall spending targets and provides guidance as to how the targets might be met. Congressional authorizing committees must meet the overall target for programs under their justification, but they are free to ignore the individual spending targets and the budget resolution's recommendations for meeting them.

The Budget panel's resolution includes about a billion less in Medicare savings than the Reagan Administration had proposed. It also lowered the savings anticipated from a physician fee freeze to $310 million in fiscal 1986 — as compared with a $500 million savings the President's budget had projected. The lower physician freeze savings stem primarily from the committee's assumption that the freeze will be applied only to MDs who did not sign Medicare participating agreements.

(Continued on page 224)

Picture Gallery

1985 Nebraska Medical Association Annual Session

Annual Session registration area.

Honors Luncheon.

NMA Board of Councilors

Dr. Warren Bosley entertaining at the Honors Luncheon.

NMA Board of Councilors

Dr. Warren Bosley

NMA Board of Councilors

Dr. Julius B. Christensen entertaining at the Honors Luncheon.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. Carl J. Formanack.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. Paul M. Bancroft.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. Clarence Mel Hartmann.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. John G. Brazer.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. James F. Kennedy.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. Julius B. Christensen.

Dr. Francis D. Donahue presenting 50-year certificate to Dr. William Riley Kovar.

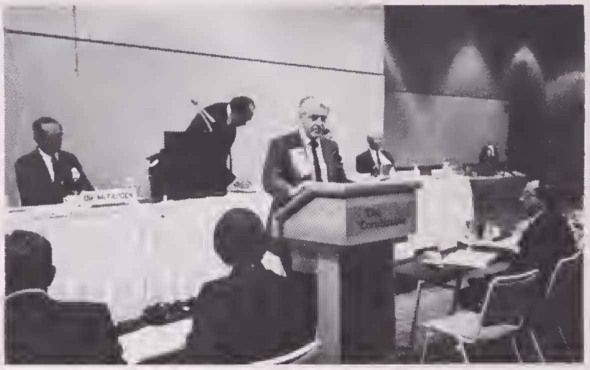
Dr. Francis D. Donahue presenting 50-year certificate to Dr. Maurice M. Steinberg.

House of Delegates

Dr. Michael Haller addressing the House of Delegates.

Dr. Gregg Wright addressing the House of Delegates.

Dr. Charles Dobry addressing the House of Delegates.



Dr. Jerald Schenken addressing the House of Delegates.

Dr. Dwaine Peetz presenting the necrology.

Dr. Craig Urbauer presenting reference committee report.

Dr. Arnold Lempka presenting reference committee report.

Senator John DeCamp addressing the House of Delegates.

Dr. Perry Williams presenting reference committee report.

Senator Dan Lynch addressing the House of Delegates.

Dr. O. R. Hayes presenting reference committee report.

Dr. Herbert Reese addressing the House of Delegates.

Dr. Robert Kruger presenting reference committee report.

Dr. Howard Saylor addressing the House of Delegates.

WashingtoNotes

(Continued from page 219)

The American Medical Association has argued against continuing the Medicare freeze for any physicians unless it was part of a broad freeze on all domestic and defense spending. AMA lobbyists told the Budget Committee members that an extension of the freeze on physician fees would make physician reimbursement the "only area in the budget that would be frozen for two years" and would mean physicians were paid at 1982 levels in 1986.

The final committee plan also differs significantly from the earlier version in that it includes an increase in beneficiary costs. Although the initial proposal had spared beneficiaries entirely, the final measure would increase Part B monthly premiums from the current 25% of costs ($15.50 a month) to 35% of costs (estimated at $34.90) in 1990. Beneficiaries would also be required to pay a new fee for home health visits after the first 20.

The plan also assumes that Medicare rates for hospitals would be frozen in fiscal 1986 and accepts the President's plan to halve payments for indirect medical education costs in 1986. Payments for the direct costs of medical education would be frozen.

For Medicaid, the budget panel opposed the President's proposed freeze on the federal share of benefits. The committee did, however, add a provision that would eliminate the federal contribution to Medicare Part B premiums states pay on behalf of Medicaid beneficiaries. Estimated savings are $300 million in each of the next three years.

The committee's resolution also endorses the Administration's plan to wipe out funds for health planning and health professions assistance in 1986. In addition, federal funding for guaranteed student loans for all areas of higher education would be reduced by $200 million in 1986. Funding for other discretionary health programs would be frozen and a 5,500 limit would be placed on new biomedical research grants from the National Institutes of Health.

* * *

Patient Protection Act

The American Medical Association is now warning medical licensing boards of about 40 cases a month in which an MD licensed in several states has just been disciplined by one of the jurisdictions, the AMA told members of the House in March.

The effort, undertaken with the Federation of State Medical Licensure Boards, followed a three-state study by the General Accounting Office that found that 10% of practitioners whose licenses were revoked in one state later billed Medicare or Medicaid for treating patients in another state.

Under current law, Medicare and Medicaid generally can exclude these practitioners only if they are convicted of fraud or abuse against the particular program involved. The GAO recommended that the Department of Health and Human Services be given authority to exclude from participation in federal health programs any practitioner who has been convicted of fraud or abuse in another federal program or whose license had been removed by a state licensing board.

Although the recommendation was supported at the time by the HHS Inspector General as well as by the AMA and other professional groups, differences developed over legislation to implement the recommendation. Swept aside as Congress got tied up in budget bills at the end of the last session, the legislation has now been reintroduced, and as a recent hearing before the House Ways and Means and Commerce health subcommittees revealed, several differences remain.

Called The Medicare and Medicaid Patient and Program Protection Act of 1985 (HR 1370), the measure was introduced by Rep. Henson Moore (R-LA) and cosponsored by many of the members of the two subcommittees. It would authorize the Department of Health and Human Services to exclude from federal health programs any provider who has been convicted of financial, patient or controlled substances abuse; who has lost or surrendered for cause a medical license or the right to participate in any federal program; or who has furnished excessive or poor quality care. An HMO could be excluded for not providing an adequate number of services.

Providers could also be excluded for failing to grant access to records or information about subcontractors or if a civil monetary penalty had been assessed against them. All exclusions would be for a minimum of five years. States would be required to notify a clearinghouse at HHS or an organization designated by HHS of disciplinary actions by state licensing boards.

Although the thrust of the bill is supported by patient representatives, physician groups and the Inspector General, some medical groups believe the legislation now goes beyond the original recommendations of the GAO while senior citizens organizations believe it does not go far enough. Debate has centered on the five year minimum exclusion, the HHS clearinghouse, and the exclusions of physicians or HMOs providing excessive or inadequate numbers of services.

Testifying for the AMA, Board of Trustees member John Ring, M.D., described the Association's use of its physician masterfile to notify the state boards of disciplinary actions against MDs licensed in more than one jurisdiction. He also reported that this effort will be expanded to notify the boards whenever the AMA learns of a physician's death.

While endorsing legislation to bar physicians who lose their license for incompetence from Medicare and Medicaid, however, Dr. Ring raised several concerns with HR 1370. The five-year minimum exclusion from federal programs does not give HHS enough discretion to deal with the "various levels of culpability" or fraud that might be encountered, he argued. An HHS clearinghouse of state disciplinary actions would duplicate efforts already taking place, and the authority to exclude providers who deliver excessive or poor quality care has been given and should remain with Peer Review Organizations (PROs).

Defending the minimum five-year exclusion. HHS Inspector General Richard Kusserow asserted that any provider that defrauds Medicare or Medicaid should be excluded from the programs "for as long as the earth spins on its axis."

The most significant difference between HR 1370 and its predecessor in the last Congress involves the addition of authority to exclude HMOs that fail in a substantial number of cases to provide all the services a patient needed. Although Kusserow and General Accounting Office official Michael Zimmerman endorsed this revision, HMO representatives contended that it is unnecessary.

Two groups representing the elderly argued that HR 1370 should be strengthened by requiring rather than permitting exclusion for certain types of fraud or abuse and by requiring public disclosure of state licensing board actions and PRO data.

The two House health subcommittees are also considering a companion bill (HR 1091) introduced by Rep. Ron Wyden (D-OR). Titled the Medical Imposters Act, the bill authorizes HHS to impose civil penalties and seek criminal sanctions against anyone who misrepresents himself as a licensed physician or as a specialist in a field in which he is not certified. The bill drew the whole-hearted support of the Inspector General and the qualified support of the AMA after Wyden agreed to work with the Association to clarify that the provision regarding specialty misrepresentation is aimed only at physicians who claim a specialty in an area of medicine for which they are not trained or qualified.

* * *

Ban on Cigarette Ads

A coalition of health organizations this month has asked the Federal Trade Commission (FTC) to take action against a recent series of advertisements which contend that the link between smoking and disease is opinion, not scientific fact.

At a news conference in Washington DC, spokesmen for the American Heart Association, the American Lung Association and the American Cancer Association called the R. J. Reynolds Tobacco Co. advertisements "false and deceptive".

"The R. J. Reynolds ad is a blatant attempt to mislead the public on the relationship between cigarette smoking and cardiovascular disease," said John Holbrook, MD, of the American Heart Association.

"We urge the FTC to put a stop to this

deceptive and self-serving campaign by R. J. Reynolds. What Americans don't know about smoking is literally killing them," said Alfred Munzer, M.D., of the American Lung Association.

R. J. Reynolds has run more than 20 "public issue" advertisements in national magazines and newspapers since early last year. The most recent advertisement attacks the Multiple Risk Factor Intervention Trial (MRFIT), claiming no significant decline in risk of heart disease in men who quit cigarette smoking.

Lewis Kuller, M.D., one of the principal investigators of the MRFIT, said that on the contrary the study found that men who quit smoking had a coronary death rate almost 50% below those who continued to smoke. The study did not intend to examine whether cigarette smoking was a cause of heart disease; in fact, the scientific evidence is now conclusive and need not be re-examined, he said.

The coalition asked the FTC to require that R.J. Reynolds pay for corrective advertisements which would support the conclusion that smoking causes coronary heart disease. In addition, it urged newspapers and magazines to stop printing the R. J. Reynolds ads or print their counter ad called "The Science of Selling Cigarettes."

A spokesman for the tobacco company accused the health groups of trying to use a government agency to "stifle those who wish to speak out with another point of view." R. J. Reynolds is prepared to answer any questions the FTC may have about their advertisements, they said.

In 1983, the US Surgeon General called smoking "the most important of the known modifiable risk factors for coronary heart disease in the United States." Cigarette smoking has been linked with an increased risk of dying for over 20 years.

* * *

'Quality' Focus of New House Bill

Contending the Medicare "cost containment" is in danger of becoming "care containment," House Aging Committee Chairman Rep. Edward Roybal (D-CA) has introduced legislation to expand quality review activities of the program's peer review organizations (PROs).

Called the Quality Assurance Reform Act of 1985 (HR 1970), Roybal's bill would require the PROs to devote as much time and resources to monitoring quality as costs and would extend PRO review to all Medicare services, including those in physicians' offices.

The bill, which follows Aging Committee hearings focusing on potential quality problems in Medicare's prospective pricing system, would:

* require that as of October 1, 1986, HHS stipulate in its award, administration and evaluation of PRO contracts that at least half of the PROs efforts are to be directed to quality review.

* extend PRO review to physicians offices, nursing homes, home health agencies, and other providers by April 1, 1988.

* direct PROs to maintain 24 hour hot lines for questions and complaints from Medicare providers and beneficiaries.

* require each PRO to have five-to-seven member Consumer Advisory Board by October 1, 1986.

* direct the Congressional Office of Technology Assessment to appoint a nine-member National Council on Quality Assurance.

* increase PRO funding as compared to current law and adjusted for inflation, by 30% in 1986, 40% in 1987, and 50% in 1988 and subsequent years.

* * *

Hospital Data to be Made Public

The government has issued a final rule that would give the public access to hospital statistics collected by peer review organizations (PROs).

The statistics would identify individual hospitals but not individual physicians.

In issuing its new rule, the Health Care Financing Administration (HCFA) rejected arguments from some business and consumer groups — including the Washington Business Group on Health and Ralph Nader's Health Research Group — that PROs should also be required to release physician-specific data.

The American Hospital Association and the American Medical Association had argued on the other hand that the final rule should scale back a proposed requirement that PROs release hospital-specific data. They argued that such information was misleading because it did not take into account the fact that some hospitals traditionally treat sicker patients.

These changes, too, were rejected by HCFA, and the final rule states that PROs "are an important source of information to aid consumers and consumer organizations in reaching informed decisions about the types of health care services that are offered." Information could include, for instance, mortality rates, costs, length of stay, volume, or infection rates by hospital or hospital department. Individual patient records may not be disclosed.

Some modifications allow hospitals an opportunity to explain its statistics, however. The PRO must give the hospital 30 days to comment before disclosing data and must include the hospitals comments with information that it releases. Another modification will permit researchers to have access only to the data the public has.

Representatives of the American Medical Peer Review Association, which represents many of the PROs, are unhappy with this change since it appears to have a detrimental effect on a research wing AMPRA has just set up. One goal of the research was to be the development of better quality of care measures and AMPRA officials believe they need physician specific data to accomplish this.

The "confidentiality" rule was one of four final regulations just issued by HCFA. The other rules govern the conduct of review, the appeals process, and sanctions under the PRO program. All have been due for months and widespread Washington rumor had suggested that the major hold up in the four sets of rules involved debate within the Administration over the release of the physician-specific information. The Office of Management and Budget was said to favor the release of the more specific information.

* * *

House Sentiment Builds Against Physician Fee Freeze

An opening round of debate in the House of Representatives over the Reagan Administration's fiscal 1986 budget proposals indicated strong sentiment for softening the President's proposal to continue a Medicare freeze on all physician fees.

In three days of hearings before the House Ways and Means Health Subcommittee, only Health Care Financing Administration head Carolyne Davis, Ph.D., defended a budget proposal to continue the physician fee freeze for all physicians. American Medical Association President-elect Harrison Rogers, M.D., said the proposal was "discriminatory and counterproductive." Rep. Willis Gradison (R-OH) called it a "breech of faith." And Subcommittee Chairman Fortney (Pete) Stark (D-CA) said he "does not intend to support postponing the fee increase" for those who signed participating agreements.

Several subcommittee members also indicated that they are considering several alternatives to the President's budget proposals. In addition to modifying the physicians freeze, these include mandating second surgical opinions for Medicare, freezing Medicare reimbursement of hospital capital expenditures and requiring some income-related cost increases for beneficiaries.

Some members, including Stark and Gradison and New York Democrat Charles Rangel, revealed substantial irritation over HCFA's failure to produce a number of reports Congress needs to make refinements in the new Medicare prospective pricing system. One such report, due in December, was to define and list hospitals that treat "disproportionate shares" of indigent patients.

Congress has indicated several times that it believes prospective rates for these hospitals should be adjusted and Stark is now working with the American Hospital Association to try to devise his own list of "disproportionate share" hospitals.

Despite repeated assertions that Medicare cuts might be acceptable as part of an across-the-board budget freeze — including defense spending and addressing some tax "loopholes" — some 20 witnesses unanimously opposed the President's present budget plan. They noted that Medicare has been cut by $25-30 billion over the past five years and suggested that changes in the system are threatening the prospective pricing system by destroying providers' faith in the government promises and eroding confidence in the quality of care.

In her defense of the physician freeze, HCFA's Davis maintained that the freeze delays (but does not break) a promise that physicians who signed participating agreements would have their fee profiles updated in October of 1985. The HCFA Administrator also said the budget anticipates that physicians will increase the volume of services they provide each patient by about 3%.

Dr. Rogers, a general surgeon from Atlanta, said that the only freeze Congress imposed in its last budget cycle was on physicians. He maintained that continuation of the freeze "would extend an unfair and extremely discriminatory practice" because "only physicians would be subjected to a two-year freeze." A continuation of the freeze, he said, would mean that Medicare payments to physicians in 1986 will be based on 1982 charges and "may prove counter-productive" since it could "discourage physicians from accepting assignment" and "treating Medicare patients." Furthermore, he said, it penalizes the 80% of physicians who responded to the AMA's call for a voluntary freeze on charges to all patients.

Responding to Dr. Rogers' comments, Rep. Stark observed that "although I rarely agree with the AMA, I just want them to know that for those physicians that responsibly accepted voluntary assignment, I think we ought to fulfill the promise that their fees would be allowed to rise."

* * *

PRO Progress Assessed by Congress

Nearly half of the nation's 54 Medicare Peer Review Organizations (PROs) have negotiated alterations in the cost and quality goals they agreed to in their contracts with the federal government.

In announcing what Medicare officials are calling "refinements" in the PRO's contract objectives, Health Care Financing Administration head Carolyne Davis, Ph.D., told a Senate subcommittee that 25 PROs have already negotiated changes and negotiations are continuing in several other states — including Rhode Island, Maine, Montana, and Wyoming.

Davis' announcement, which came at a hearing of the Senate Finance Health Subcommittee, appeared to reinforce earlier HCFA claims that the numerical objectives in the PRO contracts were not intended as quotas and were subject to change if more experience and data indicated change was warranted.

In addition to the contract changes, the HCFA Administrator also reported that four sets of long-delayed final PRO regulations had finally been released, that a Super-PRO contract to evaluate the PROs will be awarded by the end of June, and that her agency is planning pilot programs using concurrent review to prevent premature hospital discharges and to test PRO review of outpatient services.

Although the publication of the final regulations and the announcement of widespread contract renegotiations appeared to have blunted last summer's heated charges that the PRO objectives constitute arbitrary quotas, American Medical Association representative William Felts, M.D., and American Hospital Association Executive Vice President Jack Owen complained that delays in issuing the regulations have created situations harmful to physician and hospital relationships with PROs.

American Medical Peer Review Association President Howard Strawcutter, M.D., reported, however, that while PROs think HCFA is too concerned with the details and process of PRO operation, overall implementation of the program has gone well.

Sen. David Durenberger (R-MN), who crafted the law creating the PROs, remains concerned nevertheless about several other issues facing the PROs. These include OMB's "continued resistance" to the PROs, periodic reports of quality problems such as premature discharges, and a fear that outpatient services may be eating up much of the savings.

Like Durenberger, who emphasized that Congress view PROs as "Medicare's vehicles to assure quality," witnesses generally called for increased emphasis on and further improvements in the quality objectives of the PROs. Both the Senator and the professional groups urged HCFA to solicit professional and public input as contracts are redrawn and renegotiated about a year from now. All are

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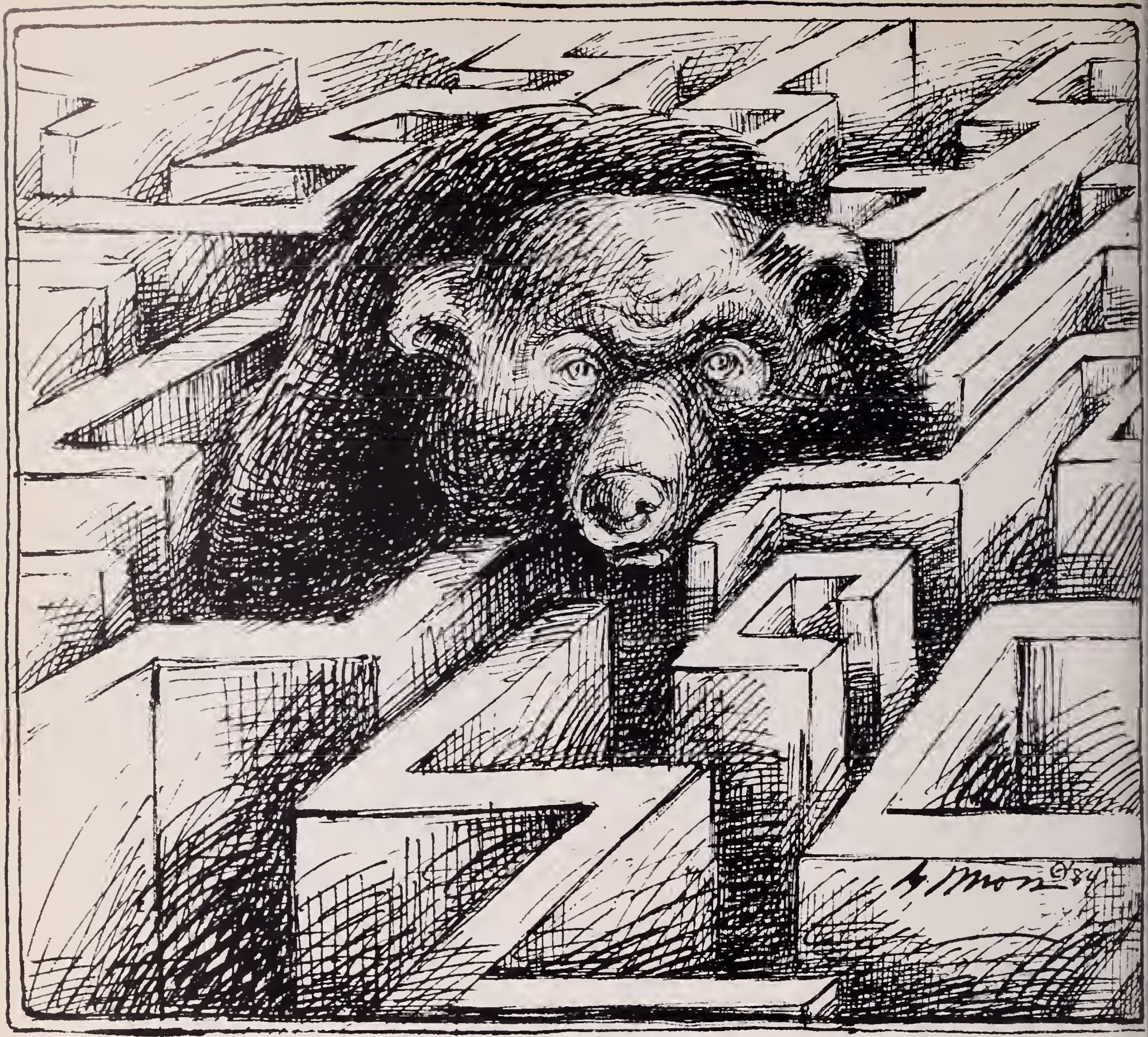

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Ad Council A Public Service of This Publication viewing the Super-PRO contract as an important part of that process.

HCFA official Phil Nathanson assured the subcommittee that the agency will have at least two semi-annual Super-PRO reports in hand before it begins to evaluate the PROs performance. But most witnesses were critical of the delay in awarding the contract which was withdrawn, redesigned and reissued after initial bids from the American Medical Association and three other organizations were determined to cost more than HCFA had available for the contracts.

Willis Goldbeck of the Washington Business Group on Health blasted the idea of the AMA evaluating the PROs as a conflict of interest. But Dr. Felts reported that the AMA will respond to the new bid proposal and will continue to oversee the PRO's progress through a new monitoring program, even if the Super-PRO contract is awarded to another bidder.

* * *

Medicare Bankruptcy Not Seen Until Near 2000

Medicare's hospital insurance fund is not likely to go bankrupt until 1998, according to the latest government report on the status of Medicare and Social Security.

The report from the Social Security Trustees also concludes that Medicare's supplementary medical insurance trust fund is "financially sound." A 1982 report predicted bankruptcy of the hospital fund by 1987 and last year's report anticipated bankruptcy in 1991.

In announcing the trustee's findings, Department of Health and Human Services Secretary Margaret Heckler attributed the improved condition of the hospital fund to "lower health care inflation and increased efficiency among health care providers, spurred in part by changes in Medicare policy."

The Secretary warned against Congressional complacency on Medicare reform, however, and said "good faith and strong medicine" will be required "in the months and years ahead."

The new projections assume enactment of the President's proposal to freeze hospital rates in 1986, and the trustees urged Congress to "take action to curtail" the rate of growth in both the hospital and supplemental medical funds.

At the end of calendar 1984 the hospital fund had a balance of $15.7 billion, $2.6 billion higher than had been predicted in last year's report. Under the trustees' most pessimistic economic assumption, the fund would remain in the black until 1992. Under the most optimistic assumption, the fund would remain healthy for at least the remainder of this century.

Under the moderate or middle range economic assumptions seen as most likely, the fund would climb steadily until it peaks at $76.3 billion in 1992 and then decline into insolvency by 1998. To produce long-term stability and keep the fund solvent over the next 25 years under this projection would require that benefits be reduced 19% or Medicare contributions increased 24%.

Unlike the hospital fund, which is financed through a payroll tax (set at 1.35% of earnings up to $39,600 this year), the supplemental medical insurance is financed through general revenues and premiums . . . In 1984, the program covered 29.4 million people and general revenue contributions amounted to $17.1 billion or 73.6% of all SMI income. About 22.3% of income came from premiums paid by the beneficiaries and the remainder came from interest payments on the SMI fund.

* * *

Physicians' Classified

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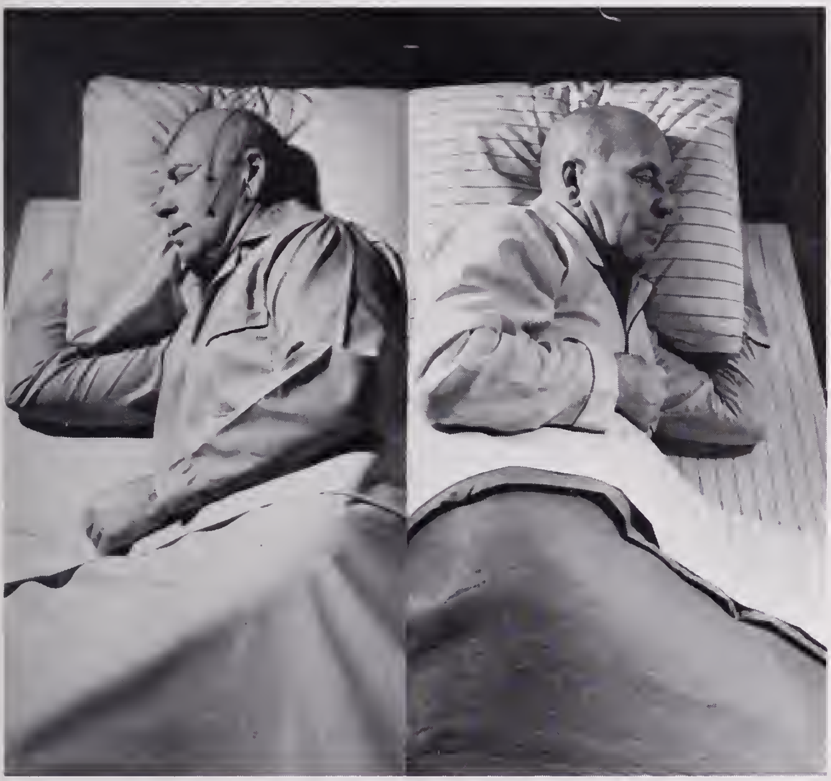

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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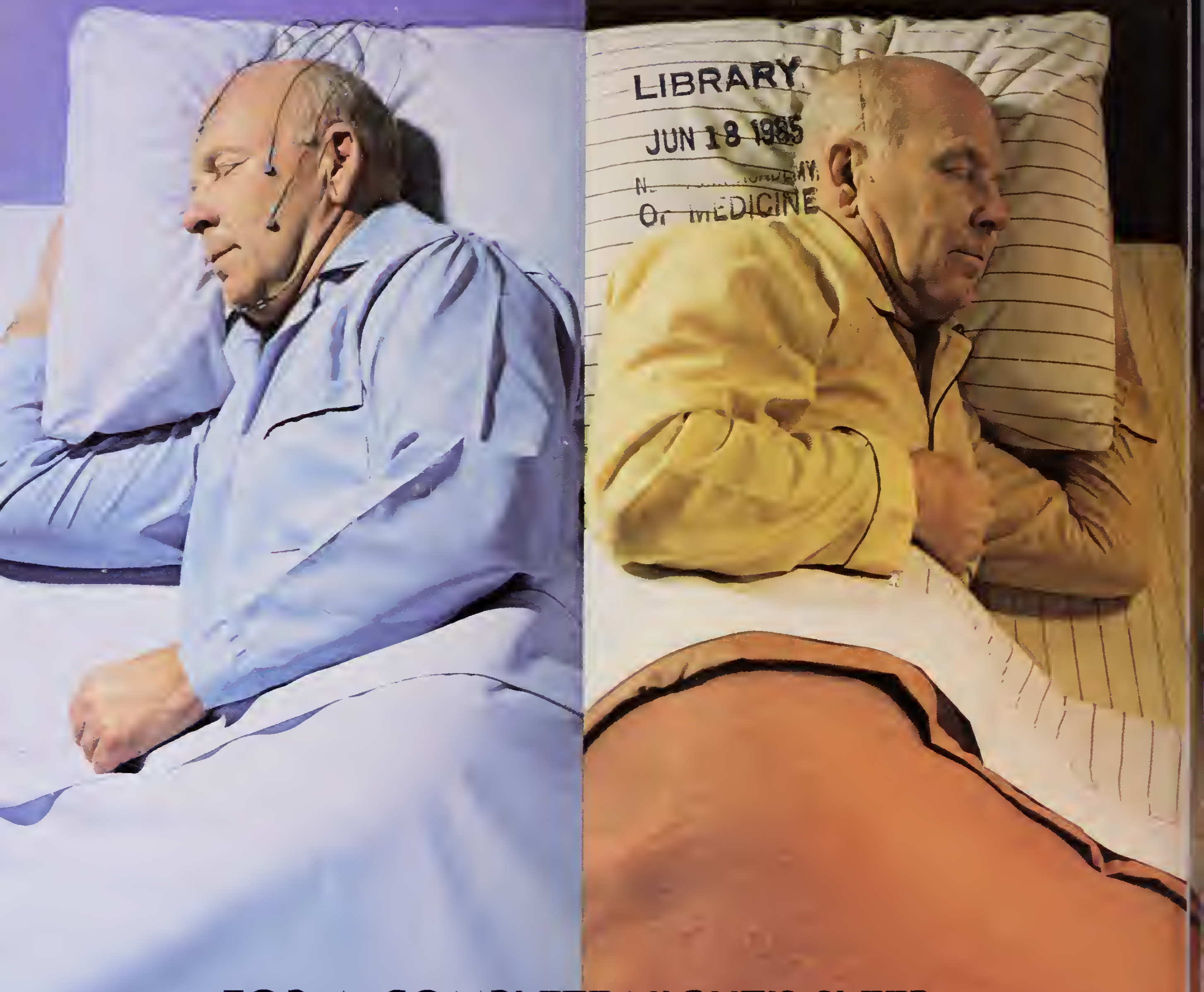

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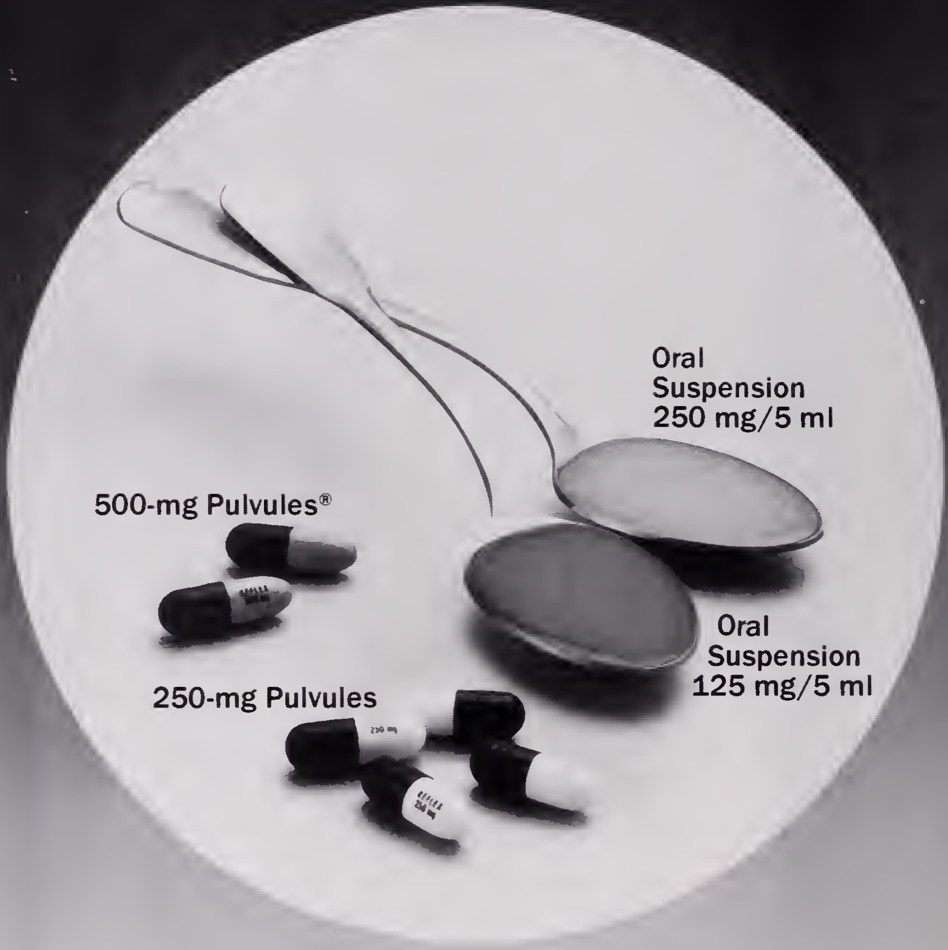

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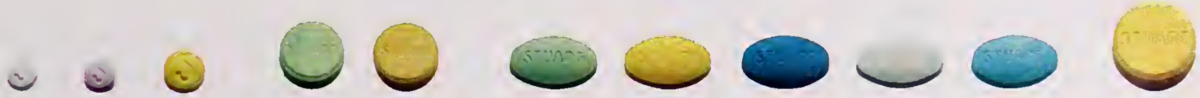

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INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg, for chewable tablets, 5 mg for oral (swallowed) tablets 5 to 20 mg and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg) Sustained Action Tablets (40 mg)

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Review articles will be considered, and should generally be limited to less than 4,000 words and approximately 30 references.

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Feds Urge DPT Shots

Physicians should resume giving the complete DPT schedule of vaccines to the 2 million children whose shots had been postponed during the recent vaccine shortage, federal officials have announced.

On April 25, Connaught Laboratories once again offered full-scale distribution of the vaccine, ending the shortage. An estimated 2.2 million doses now are ready for immediate shipment to doctors and public health officials.

Because of the shortage, the Public Health Service asked physicians to postpone administering the fourth and fifth doses of the vaccine, usually given to children 18 months and 4 to 6 years of age. Now, supplies are adequate to meet national needs.

It is especially important to provide the DPT vaccine to children scheduled to enter kindergarten or first grade this fall, PHS officials say.

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Please see brief summary of prescribing information on the next page for further details.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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WashingtoNotes

Taking the Stick to Graduate Medical Education

Federal budgetary pressures, a predicted surplus of physicians and cost-conscious insurers and businesses are forcing medical educators to reassess both the funding and the makeup of the graduate medical education system.

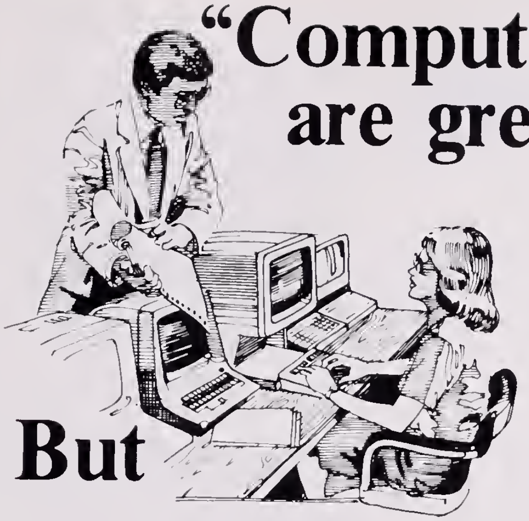
Funded primarily through patient revenues, the design of the system — widely acknowledged as one of the world's finest but frequently accused of turning out an army of specialists in a world that needs more primary care physicians — until now has been left largely in the hands of physicians and the medical schools and hospitals which train them. Federal attempts to influence graduate medical education were limited to the carrot approach as various subsidies were offered to encourage the graduate training of primary care physicians.

But the national debate that initially focused simply on curbing Medicare spending has now been expanded to include the possiblity of using Medicare as a stick to shape graduate medical education.

The Reagan Administration has proposed to cut Medicare payments for medical education and eliminate all federal grants for health professions training.

Sen. Dan Quayle (R-IN), who has suggested a plan that would provide Medicare reimbursement only to training programs in which at least 70% of residency positions were in primary care and at least 75% of the residents were graduates of American schools approved by the Liaison Committee on Medical Education. The plan, which Quayle outlined at a hearing of the Senate Labor and Human Resources Committee, would also require that hospitals and other teaching programs have an affiliation with a medical school. The 70/30% ratio of primary care to specialty physicians might be applied to some larger base than individual institutions, and a national commission would be set up to determine whether the ratio is appropriate and to recommend changes in the future.

(Continued on page 12A)



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Cost: self-study course — $395
six-day course — $475

WashingtoNotes

(Continued from page 11A)

A number of other Congressmen are also designing proposals to modify Medicare's approach to graduate education costs. At an April hearing of the House Commerce Committee Health Subcommittee Chairman Rep. Henry Waxman (D-CA) pointedly contrasted the "cost-based and open-ended" Medicare and Medicaid approach with "limited" and "sharply focused" federal grants for health professions training.

Other Senate players in addition to Quayle include Majority Leader Robert Dole (R-KS) and Finance Health Subcommittee Chairman David Durenberger (R-MN). Durenberger, who sparked Congressional interest in medical education funding last fall, has backed away from a block grant approach he introduced at that time. He is now working with Dole and Sen. Lloyd Bentsen (D-TX) to design an alternative to the President's budget proposals. As an alternative to the Reagan Administration's proposal to halve the current 11.59% factor Medicare uses to adjust payments for indirect costs of medical education, the Sena-

(Continued on page 280)

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Immanuel Medical Center

ONCOLOGY FELLOWSHIP PROGRAM — SEPTEMBER 12-13, 1985

A two-day continuing education program in Oncology for primary care physicians will be held at Holling Education Center, Immanuel Medical Center, September 12-13, 1985. This program is designed to enhance physician's diagnosis, treatment and follow-up skills in dealing with the most prevalent oncology diagnoses. Continuing Medical Education (CME) credits are offered for participation in the program.

Spouses are invited to participate in special activities; participants and faculty will enjoy an evening of elegant "dining out" together on Thursday, September 12. Participants are housed at the beautiful new Immanuel Plaza Motel on the Medical Center campus.

An agenda for the two-day program is as follows:

First Day

- Introduction to Cancer
  - John B. Davis, M.D.
- Principles and Treatment of Cancer:
  - Radiation Oncology
  - Chemotherapy
    - David J. Harter, M.D.
    - Herbert A. Hartman, Jr., M.D.
- Imaging Modalities
  - Paul Bender, M.D.*
  - W. Benton Copple, M.D.*
- Primary Oncologic Emergencies
  - John J. Hoesing, M.D.
- Colon Cancer Update
  - Mark Christensen, M.D.
- Tumor Markers
  - Thomas A. Ruma, M.D.
- The Black Spot - Malignant Melanoma
  - John F. Latenser, M.D.
- Lung Cancer Update
  - Leonard Moss, M.D.
  - David A. Hughes, M.D.
- The Role of the Family Physician in the Treatment of Cancer
  - Ronald C. Bell, M.D.
- Tour of Radiation Oncology

For more information on this or future Fellowships, contact Marion Kaple, Holling Education Center, Immanuel Medical Center, 6901 North 72nd Street, Omaha, Nebraska 68122, (402) 572-2340.

Second Day

- Tumor Conference
  - John B. Davis, M.D., Moderator
  - Panel — Medical Staff representing Hematology, Medical Oncology, Pathology, Gynecology, Surgery, Radiology, Urology, General Family Practice, Internal Medicine
- Gynecologic Tumor
  - Leon S. McGoogan, M.D.*
  - Terrence J. Kolbeck, M.D.*
- Chronic Lymphatic Leukemia
  - John R. Feagler, M.D.*
  - Joseph D. Verdirame, M.D.*
- Multiple Myeloma
  - John R. Feagler, M.D.*
  - Joseph D. Verdirame, M.D.*
- Control of Pain in the Cancer Patient
  - David J. Harter, M.D.
- Skin Tumor, Diagnosis and Treatment
  - John F. Latenser, M.D.
- Breast Cancer Update
  - John B. Davis, M.D.
- Cancer Screening in the Physician's Office
  - William A. Shiffermiller, M.D.
- Prostatic Carcinoma
  - Stewart E. Sloan, M.D.*
  - Gerald C. Felt, M.D.*
- Liver Pumps and Hickman Catheters
  - Thomas Connors, M.D.
- Follow-Up of Cancer Patients
  - John B. Davis, M.D.

*Session presenter rotates for each Fellowship Program.

THE NEBRASKA MEDICAL JOURNAL

The Health Care Professional's Role in Occurrence of Cerebral Palsy

THE number of patient's charts that I was asked to review in 1984 concerning cerebral palsy, allegedly due to malpractice, increased more than four times when compared with any other previous year since my arrival in Omaha in 1979. Health care professionals in our state need to consider how to avoid letting the malpractice problem escalate, as I saw happen in California during the 1970's.

During 1984, I attended five conferences relative to the role of the physician in the occurrence of cerebral palsy, two of which were held in Europe. The conferences in the United States appeared to be concerned about how to prevent the filing of malpractice suits over cerebral palsy against hospitals and their staff. Those in Europe were concerned with the etiology, prevention, and especially the care of the children with cerebral palsy. The differences in legal climate between the two continents may explain these contrasts in degree of apparent empathy expressed publicly by the health care professionals for the patients and their families. Nevertheless, I believe that in order to gain control of the malpractice situation, we must refocus our public image and stance about the problems of cerebral palsy.

In Nebraska, the human fetus as well as its mother relies upon the family practitioner or obstetrician as his or her physician and we are, therefore, responsible for its outcome. Most of us accept the credit and gratitude of families when all turns out well. When cases of in utero cerebral palsy or dysfunction occur, I argue that we are, likewise, responsible. From the theoretical standpoint, lack of knowledge of in utero factors does not absolve us of the responsibility. However, providing our lack of knowledge is no less than other physicians, it appears we are spared the legal consequences when such unfortunate cases occur.

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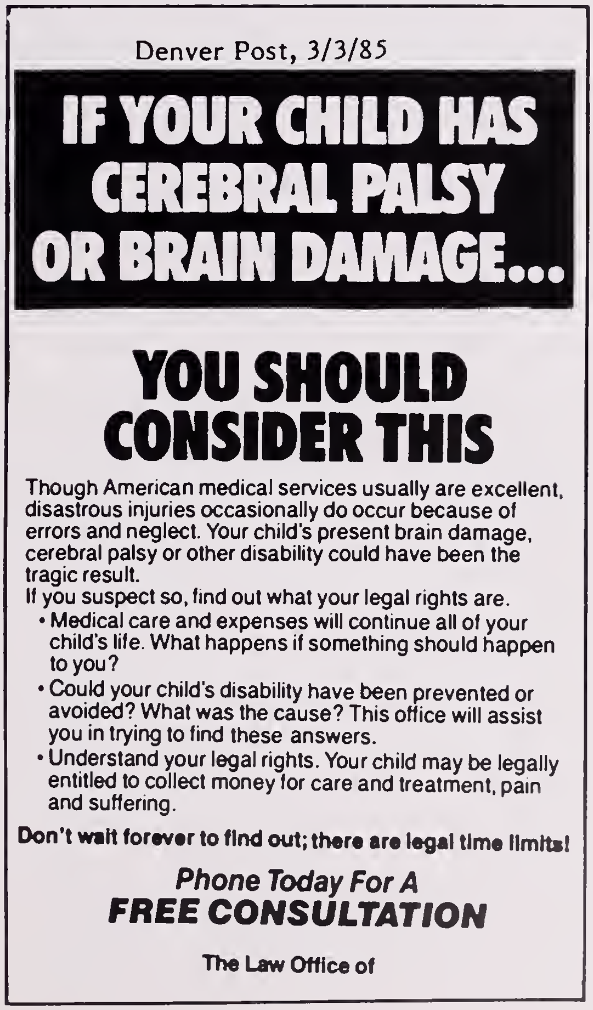
During the 1950's and 1960's, more than $130,000,000 was spent by The Collaborative Project (NICHID) in an effort to find the cause and prevention of cerebral palsy. Their con-



Denver Post, 3/3/85

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Figure 1

cepts seem simplistic in retrospect, although their idealism and work provided us with much important information. We could now, for instance, repeatedly study with real time ultrasound a large number of fetuses' neurological responses and learn when and after what in utero event any neurological abnormality occurred.[1] Just because cerebral palsy is extremely difficult to produce in laboratory fetuses, does not suggest that we will be unable to delineate the responsible in utero factors.

When speaking to state legislatures for relief from the potential malpractice situation, I believe health care professionals should also speak more strongly in behalf of research and child care monies for the victims of cerebral palsy. The parents of tiny newborns who require respiratory therapy now receive special support, mostly because of past efforts of neonatologists and social workers working in state legislatures on behalf of everyone. Likewise, the families of children with cerebral palsy should receive special help and benefits. Recent advertisements in Denver newspapers (Fig. 1) suggest that such families now can receive help only from "understanding and friendly" trial lawyers. Our society should provide other alternatives which could be less costly and more just.

For these many reasons, the health care profession needs to take more responsibility for the prevention and especially the care of children with cerebral palsy. As with workman's compensation laws, if mechanisms were available to provide children with cerebral palsy the best of care on a no fault basis, the need for these frequent and huge malpractice suits might disappear.

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Unusual Complication of Central Venous Catheter: A Case Report

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PERCUTANEOUS catheterization of the subclavian vein was first reported by Aubaniac in 1952.[1] Ten years later, it was popularized in America by Wilson.[2] In the late 1960's, Matthews introduced the technique of percutaneous internal jugular venipuncture in adults, which in the past had been primarily used in children.[3] Now these procedures are commonly used to gain access to the superior vena cava in order to administer fluid and drugs, monitor the central venous pressure, insert a Swan-Ganz catheter, implant a temporary or permanent transvenous pacemaker, total parenteral nutrition, and to place peritoneo-venous shunt.

Complications following percutaneous central venous catheterization have been thoroughly reviewed by McGoon.[4] The incidence of complication varies from 0 to 21%.[5,6] This depends primarily upon the experience of the operator and the strictness with which the staff follows the protocol to manage the catheter once it is in place.

An unusual complication of this procedure is reported in a patient who had central venous catheterization done in the surgery suite before being placed on cardiopulmonary bypass. To the best of our knowledge this is the first such report in the English literature.

Case Report

A 59-year-old patient had repair of a posterior left ventricular aneurysm and closure of an ischemic ventricular septal defect (VSD) for progressive heart failure following a massive inferior wall myocardial infarction on July 23, 1972. Postoperatively, a residual murmur of VSD was audible. The patient did well up until the summer of 1981, when he began to experience severe progressive angina upon minimal exertion. Cardiac catheterization revealed a residual ventricular septal defect with a 33% left to right shunt. There was critical stenosis in the proximal left anterior descending, obtuse marginal and posterolateral branches of the left circumflex coronary artery. On November 25, 1981, the patient underwent repeat closure of the ventricular septal defect and saphenous vein bypasses to left anterior descending, obtuse marginal branch and posterior branch of the left circumflex coronary artery. Before induction of anesthesia, a right internal jugular vein catheter was placed by the anesthesiologist and herparin was given through this catheter. Adequate ACT levels were obtained.

There was no difficulty in coming off the bypass. After protamine was given through the same central venous catheter to reverse the effect of heparin, no clots were seen in the operative field, and the ACT remained high. The patient started to have a progressive drop in his systemic blood pressure with low left atrial pressure. More volume was being given through the central venous line simultaneously, but there was no rise in left atrial or systemic pressure. At this time, dislodgement of the central venous catheter was suspected. There was no hematoma in the neck, but on lowering the fluid bag for the internal jugular vein catheter line, no backbleeding into the intravenous tubing was observed. The right pleural space was entered and there was no blood or fluid accumulation within the right pleural space but a massive extrapleural hematoma was appreciated. About three liters of fluid and clots were evacuated from this site and the catheter tip was felt. The central venous catheter was then removed and a new venous line was started per right saphenous vein. Subsequently, the patient had an appropriate rise in the left atrial and systemic pressures and left the surgery suite. His entire postoperative course was uneventful and he was dismissed on 12/2/81.

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Discussion

Internal jugular vein catheterization is reported to have a lower incidence of complication than that with subclavian vein.[4] Common complications resulting from internal jugular route are puncture of the carotid artery and catheter sepsis.[7] In our opinion, complication rate really rests upon the experience of the operator. However, in our patient, the central venous catheter was initially inserted correctly via internal jugular vein. It was in the lumen of the vein as was evidenced by the fact that blood had drained back into the venous tubing. Moreover, before going on the cardiopulmonary bypass, the patient had been given heparin through this portal and an appropriate rise of the ACT was registered. As this patient had a "fixed" mediastinum due to adhesions from his previous cardiac surgery, and as there were pleural adhesions in the apical area of the right hemithorax, the catheter tip pierced the vein wall while sternum was being spread, and lodged in the potential right extrapleural space. Understandably, there was no hematoma in the neck or extravasation of fluid in the mediastinum or in the right pleural space.

Since opening the sternum distorts the mediastinal vessels, position of the venous catheter should be rechecked by lowering the fluid bag once the sternum is spread. It becomes even more important when the mediastinum is fixed due to fibrosis or prior surgery. Moreover, one should use the newer, softer silastic catheter than the rigid plastic or teflon ones, which are more prone to perforate the wall of the vein. Physicians are advised to be constantly on the lookout for various complications that can occur with this frequently performed procedure.

Summary

A case, where the central venous catheter tip was displaced into extrapleural space during cardiopulmonary bypass, is reported. This resulted in massive fluid loss into a potential space. To avoid this complication, one should use softer material catheters, and the position of the central venous catheter should be rechecked once on and before coming off the cardiopulmonary bypass.

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Group A Streptococcal Meningitis in an Adult

STREPTOCOCCAL meningitis is most often due to a beta hemolytic streptococcus. Quite common in the pre-antibiotic era, this infection is now rare. We report a case of group A streptococcal meningitis in an adult.

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Case Report

A 63-year-old woman was admitted to the hospital because of fever and obtundation. She had a pustule on her right index finger which resolved one week before admission. There was a five day history of headaches, sinus congestion, and sore throat. Her past medical history was significant for primary billiary cirrhosis diagnosed seven years earlier by liver biopsy.

On examination she was obtunded but responded to simple commands and pain. The temperature was 103° F; the blood pressure 120/70 mmHg; and the pulse 90 and regular. The respirations were 34 and shallow. There was marked nuchal rigidity. The posterior pharynx was erythematous and the right tonsil was swollen with minimal exudate. The cardiopulmonary exam was unremarkable; the liver percussed to 16 cm in the midclavicular line. She was nonicteric, and there were no focal neurologic findings.

Lumbar puncture was performed. The cerebrospinal fluid (CSF) revealed a protein of 625 mg/dl, and a glucose of 7 mg/dl. There were 99 white cells (52% lymphocytes and 48% polymorphonuclear cells) and 101 noncrenated red cells. Gram stain revealed gram-positive cocci in pairs and chains; counterimmunoelectrophoresis for **Hemophilus influenzae, Neisseria meningitidis,** and **Streptococcus pneumoniae** was negative. Culture of the CSF grew beta-hemolytic streptococcus, identified as Group A by Streptex kit.[1] Four of four initial blood cultures were positive for Group A streptococcus, which was also recovered from an oropharyngeal culture. The ASO titer was 250 Todd units (normal: less than 166 units). The peripheral white cell count was 18,800 with a marked shift to the left. The serum sodium was 127 mEq/L; albumin 2.8 g/dl; calcium 7.8 mg/dl (normal: 8.4-10.4 mg/dl); alkaline phosphatase 401 units/ml (normal: 30-120 units/ml). Urine culture was negative. Chest x-ray revealed basilar atelectasis and minimal patchy consolidation. Sinus films showed left maxillary thickening with no evidence of active sinusitis. Computerized tomography of the head was normal; cervical spine films revealed only osteoarthritis.

The patient was treated with 24 million units of penicillin G intravenously daily in divided doses for 14 days. Within 48 hours her mental status had improved. At the conclusion of therapy, there was no evidence of residual neurologic deficit. Her course was complicated by significant fluid retention, likely secondary to hyperaldosteronism. She responded to bedrest and spironolactone, and was discharged in good condition.

Discussion

Group A streptococcus is found primarily on the skin and in the pharynx of humans. This organism is responsible for a wide variety of suppurative infections with a significant incidence of toxigenic (scarlet fever) and immunologic (rheumatic fever, glomerulonephritis) sequelae. Historically, it has been a major pathogen. However, during this century there has been a marked decline in the incidence and mortality of many Group A infections, especially scarlet fever, pneumonitis, and erysipelas, a trend perhaps beginning even prior to the widespread use of antibiotics.[2] A decline in the incidence of certain infectious sequelae of streptococcal pharyngitis — peritonsilar abscess, mastoiditis, otitis — has been documented since the introduction of antibiotics in the 1930's and 1940's.[3]

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Hemolytic streptococci were a common cause of meningitis, accounting for seven percent of adult cases and eight percent of pediatric cases in one New York survey.[4] Prior to the widespread use of sulfonamide drugs, the mortality was 95 percent. The incidence of streptococcal meningitis began to decline in the 1940's[3] and it accounted for three percent of meningitis cases in another New York survey in the early 1950's.[5] Lancefield typing, first introduced in 1933, was not reported for these cases of streptococcal infection, but epidemiological data suggest that the organisms were Group A or **Streptococcus pyogenes.**

In recent surveys of bacterial meningitis, **S. pyogenes** has virtually disappeared as a significant pathogen, especially among adults. The Mayo clinic reported a ten year experience with bacterial meningitis (1948-1958) in which ten percent of cases were streptococcal.[6] However, most of these were **S. faecalis** or viridans group of streptococci, and only three patients were infected with **S. pyogenes.** More recently, Lerner found ten cases of streptococcal meningitis upon surveying four Cleveland hospitals over a five year period (1969-1974),[7] but none were Group A infections. A ten year survey of meningitis in Birmingham, England (1968-1977) revealed three cases due to **S. pyogenes,** all in children less than one year of age.[8]

Group A streptococcal meningitis does remain a rare, but significant illness in the pediatric population.[9] Murphy found six cases at a children's hospital in Cincinnati over a fifteen year period.[10] One case has been reported during a community outbreak of streptococcal pharyngitis.[11]

Few cases of Group A streptococcal meningitis in adults have been reported over the last decade. Hempling and Coutihn reported a fulminant case involving a 31-year-old woman with no obvious predisposing condition.[12] Karandanis and Shulman listed one adult case of Group A streptococcal meningitis in a large survey, but provided no details except that the patient died.[13] Jones, Luby and Sanford reviewed 22 cases of post-traumatic meningitis, identifying one patient whose Group A infection developed after a skull fracture traversing the frontal sinus.[14] This patient recovered after treatment with ampicillin. Recently, a case was reported involving an 80-year-old woman whose meningitis was presumed secondary to Group A streptococcal septic arthritis.[15] She failed on therapy with cefotaxime, but responded rapidly to penicillin.

Our patient's meningitis may have developed secondarily from her tonsillitis. It has long been a matter of controversy whether meningitis in the setting of nasopharyngeal infection is due to hematogenous or contiguous spread, especially in the absence of trauma or anatomic anomaly. She had neither of these. Her bacteremia may have been antecedant to or secondarily from her meningitis.

Summary

A 63-year-old patient is reported with **S. pyogenes** meningitis. She responded promptly to intravenous penicillin, which is the drug of choice for this infection.[16] A ten day course is usually curative unless a parameningeal focus exists. This case serves as a reminder that **S. pyogenes** remains, in rare instances, a potentially virulent pathogen in the adult population.

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Case Report: Sub-Normal Serum Thyroxine Levels Associated with Carbamazepine and Valproic Acid Treatment

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A BOY, aged eleven years, with long-standing diabetes mellitus and a convulsive disorder, was found to have sub-normal levels of thyroxine in association with normal values for thyroid stimulating hormone and was clinically euthyroid. His anticonvulsant therapy included both carbamazepine and valproic acid. A review of the literature suggests that the frankly sub-normal thyroxine level was an effect of the anticonvulsant drugs and this would appear to be the first case report in a patient treated with both of these anticonvulsants concurrently.

Case Report

An 11 year, 8 month-old patient, with a diagnosis of diabetes mellitus since the age of 4 years, was admitted to Children's Medical Center, Dayton, Ohio, in June 1978 for improvement in his general management and adjustment of insulin dosage. He was small for his age with a height of 135.4 cm and a weight of 27.9 kg.

The boy had been diagnosed as epileptic at the age of 9 months. At the time of admission, his seizures were controlled with carbamazepine 200 mg t.i.d., valproic acid 250 mg in the morning, 500 mg at night, and clonazepam 2 mg b.i.d. He had been taking carbamazepine for four years, valproic acid for almost three months and clonazepam for four years.

Concomitant medications were pemoline (Cylert) 37.5 mg each morning (duration 10 weeks) and Drixoral tabs 1 daily (duration 20 months), the last-mentioned drug having been prescribed for allergic rhinitis.

By the time of discharge, it had been concluded that the small stature was essentially due to less than adequate control of the diabetes, but as part of his investigation, serum total thyroxine (T4) was measured using a Thyrolute reagent kit (Ames Company, competitive protein-binding principle). The initial value obtained was 4.1 μg/100 ml, (adult normal range 5.3-14.5μg/100 ml, calculated normal range for a child of this age 4.5-12.5

μg/100 ml[1]) whereas the TSH from the same serum was in the normal range at 3.0 μIU/ml (Abbott Laboratories, Human Thyroid Stimulating Hormone Radioimmunoassay Kit). The result for ^{125}I Radioassy for T^3 Uptake (Ames Company, Trilute Kit) on serum taken two days later was 34.5% (normal 25-35%).

A subsequent specimen of serum analyzed in Bio-Science Laboratories gave a T4 by R.I.A. of 4.4 μg/100 ml (adult normal range 5-12) and a free thyroxine level of 1.3 ng/100 ml (normal 1.0-2.3 as T4). Assays for anti-thyroglobulin antibodies and for antimicrosomal antithyroid antibodies were negative.

In summary, the patient appeared to be euthyroid and gained in height and weight following better control of the diabetic state. It thus seemed likely that the low serum level of total T4 was a drug-induced effect. Since both the T3 uptake and the TSH levels were normal, administration of both carbamazepine and valproic acid was continued and it was the intention to monitor thyroid function periodically.

Discussion

It has been well established that the anticonvulsant phenytoin may affect thyroxine metabolism and lead to a lowering of serum thyroxine levels. An early report that carbanmazepine may also reduce thyroxine (T4) levels in euthyroid patients was published in the German literature by Fichsel and Knöpfle in 1977.[2] The same authors mentioned this effect in another German article in which the effects of combination therapy utilizing longer-known anticonvulsants was described and the possibility that valproate could also participate was raised.[3]

A review of these studies from Germany was published in English in 1978.[4] In the same year, Liewendahl et al.,[5] in Finland, also showed that patients treated with carbamazepine showed a relative decrease in serum T3 (tri-iodothyronine) as well as in serum T4 compared with control subjects. In this Finnish study, the patients on valproate had serum thyroid hormone values within the normal range.

Subsequent work has confirmed that carbamazepine therapy is associated with, or directly leads to, reduced serum levels of T4, free T4 and T3,[6,7,8,9,10,11] yet in no study quoted has there been a sustained rise in pituitary TSH secretion in response to the fall in circulating T4 and T3. In only two of the long-term studies was a reduction in thyroid-binding globulin observed.[8,10] The effects of the drug on thyroid hormone concentrations are most likely due to hepatic enzyme induction.[11]

Fortunately, to the authors' knowledge, there have only been two reports of clinical hypothyroidism developing in patients on carbamazepine and only one instance of this occurrence when the drug was used as the only anticonvulsant.[12] In this adult patient, the TSH level was raised during the episode of hypothyroidism which proved reversible when carbamazepine was withdrawn. Only 5 of the 42 patients discussed by Strandjord et al[8] had T4 levels below the normal range during carbamazepine therapy, without other evidence of hypothyroidism.

The effect of valproate on serum levels of T4, first noted by Fichsel and Knöpfle,[13] and considered by them to be less than that of other anticonvulsants,[4] has been verified by Bentsen et al[10] who found that the drug caused decreases in serum levels of T4 and T3. None of their eight patients on valproate alone became hypothyroid and none showed an increase in thyroid stimulating hormone during therapy.

For completeness, it must be mentioned that Liewendahl et al.[5] found any effect of valproate on thyroid hormone levels to be insignificant, and there is certainly no acceptance of this side effect of the drug being a disadvantage in clinical practice.

The phenomenon has been studied by Elias et al.[14] who found no fall in T4 in seven normal controls and in six patients with primary hypothyrodism during valproate administration. However, serum T3 did fall significantly in all subjects. There was also a decline in the stimulated serum TSH responses to thyroid releasing hormone.

Since valproic acid is an inhibitor of gamma amino butyric acid (GABA) transaminase, these authors suggested that valproic acid, through protection of GABA, might result in inhibition of TSH release at the level of the pituitary gland, or it might act by inducing the secretion of a hypothalamic TSH inhibiting factor. They agree that their data do not exclude a direct pharmaceutical effect of valproic acid on pituitary TSH release. The mechanism for the decrease in T3 following valproate remains unexplained.

Whatever the mechanism, in clinical practice patients on carbamazepine or valproate should have thyroid function monitored periodically.

Although valproate by itself does not appear to create clinical hypothyroidism, since there is a suspicion that it may hinder a normal TSH response in incipient hypothyrodism, it is probably wise not to use it in combination with carbamazepine if control of epilepsy can be achieved without use of the two drugs simultaneously. Patients controlled on both drugs should have thyroid hormone levels monitored with particular care.

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Nebraska Stillborn Survey - 1981

PREVIOUSLY the 1980 stillborn statistics were presented in the January 1984 issue of the Nebraska State Medical Journal. That article also cited discrepancies and suggested recommendations. This article will present the 1981 stillborn statistics and compare this data with the 1980 data.

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The information was obtained from required State Stillborn Certificates and requested data send by the attending physician to the Nebraska Medical Association AD HOC Committee on Maternal and Child Health.

In defining and reporting fetal demise, discrepancies still remain between medical personnel. The following definition is presented as a suggested format to follow. This was presented in the American College of Obstetrics & Gynecology and Academy of Pediatrics in 1983 under "Guidelines for Perinatal Care".

FETAL DEATH: Death prior to the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Fetal death is subdivided according to the timing and mode.

1. Early fetal death (abortion): The expulsion or extraction from the mother of a fetus or embryo weighing 500 g or less (about 22 weeks' gestation). This definition excludes induced terminations of pregnancy.
2. Late fetal death (stillbirth): Death prior to expulsion, extraction or delivelry in which fetal weight is greater than 500 g or, if weight is unknown, the duration of the pregnancy exceeds 22 completed weeks' gestation. When neither birth weight nor gestational age is available, a body length of 25 cm (crown-heel) is considered equivalent to a 500-g weight.
3. Induced termination of pregnancy. The deliberate interruption of pregnancy - to produce other than a liveborn neonate or to remove a dead fetus - that does not result in a live birth.

There were 202 stillborn cases reported to the State Department in 1981. (Table I) This represents a 5.7% increase over 1980. The proportion between primigravida and multigravida remained approximately the same.

Among the stillborn cases reviewed there was a 58% increase noted in teenage pregnancies and a 240% increase in women between ages 30-34 years. (Table II) A 66% decrease

TABLE I

NUMBER OF STILLBORN CASES IN NEBRASKA

	1980	1981
STILLBORN CASES	191	202
PRIMIGRAVIDA	71	80
MULTIGRAVIDA	108	115
NOT NOTED	12	7

TABLE II

AGES OF PATIENT

	1980	1981
14 - 19	24	38
20 - 24	71	61
25 - 29	59	59
30 - 34	10	34
35 - 39	23	6
40 - Plus	4	3
Unknown	0	1

was noted in women over the age of 35 years. The increase seen between ages 30-34 may reflect the trend of women starting families at a later age.

The gestational age of the pregnancy is presented in Table III. The number of stillborns, 37 weeks and beyond, was 65 in 1981 as compared to 63 in 1980. There was a significant decrease in the number of pregnancies extending beyond 42 weeks gestation. The number reported as less than twenty weeks, and not truly stillbirths, were approximately the same for the two years. One case documented an APGAR at 1 and 5 minutes and was still inaccurately reported as a stillborn.

TABLE III

GESTATIONAL AGE OF STILLBORN IN WEEKS

	1980	1981
Less than 20	6	7
20 - 24	35	44
25 - 28	17	25
29 - 32	24	23
33 - 36	36	30
37 - 39	17	30
40 - 42	34	32
42 - 44	9	3
44 - Plus	3	0
Unknown	10	7

One hundred and thirty-seven cases reported fetal demise occurring prior to labor but 44 cases reported the fetus dying during labor. Table IV lists the reasons stated on the Stillborn Certificates. A significant number of cases stated that fetal heart tones were heard prior to transfer of the patient to the delivery room but a stillborn was delivered. Of these cases a cord involvement was noted as the most common cause listed for fetal demise.

In 1980 sixty percent of cases reported postmortem examinations, where as in 1981 forty-seven percent reported autopsies. The reports varied from very detailed to stating an inability to examine because of marked degenerative changes. In the majority of cases the autopsy findings as presented did not contribute or change the original concept for fetal demise.

There were 20 and 23 cesarean sections performed in 1980 and 1981, respectively. The ten most common reasons for cesarean section for 1981 are listed in Table V and compared to reasons given in 1980. Totals do not necessarily equate as more than one reason was given in some cases.

TABLE IV

DIAGNOSIS GIVEN FOR FETAL DEMISE DURING LABOR ONLY

REASONS STATED	1981
IUGR	1
Incompetent Cervix	8
Abruptio Placenta	7
Anencephaly	7
Prematurity	5
Cord Involvement	5
Fetal Hemmorrhagea	2
Cardiac Anomaly	1
Preeclampsia, Severe	1
Ruptured Uterus	1
Breech - ACH Dystocia (Premature)	1
Unknown	5

TABLE V

NUMBER OF CESAREAN SECTIONS, AND REASON FOR C/S

	1980	1981
Cesarean Sections	20	23
REASONS STATED		
Twins	2	2
Hemmorrhagea	7	4
Breech	1	
Repeat C/S	5	6
Failed Induction	1	
C.P.D.	1	1
Ruptured C/S Scar	1	
Ruptured Uterus		1
Fetal Distress		11
Hydrocephalic		1
Transverse Lie		2
No Reason Stated	2	

Fetal distress was a new category reported in 1981 that was not reported in 1980. Several cases presented data that stated "questionable" fetal heart tones were heard prior to C-Section. At the time of delivery, however, degenerative changes were noted that would indicate fetal demise had occurred at least 24 hours previously.

All C-Sections were felt to be indicated by reasons indicated in the presented data sent to the committee. The ability to determine fetal death in-utero, however, needs improvement.

The diagnostic impressions listed on the Stillborn Certificates are presented in Table VI. Inadequate or incomplete data presented to justify the diagnosis was evident in 33 cases in 1981 as compared to 58 cases in 1980. The diagnostic categories listed as unknown, placental involvement, cord involvement and congenital malformations, especially anencephaly, increased in number of cases. Other new categories are noted below.

Vaginal prostaglandin suppositories were utilized for induction in an increasing number of cases. From the information presented, both types of induction used (oxytocin and prostaglandin) listed complications, but complications listed were less in number following the use of vaginal prostaglandin.

TABLE VI

DIAGNOSIS FOR STILLBORN AS INDICATED ON CERTIFICATE

		1980	1981
No Diagnosis Given		9	2
Unknown		39	65
Placenta Involvement		24	42
Abruptio	22---30		
Previa	1		
Insufficiency	1--- 8		
Infarct	4		
Cord Involvement		27	35
Congenital Malformations		12	21
Multiple	6--- 1		
Anencephaly	4---11		
Hydrocephaly	2--- 3		
Trisomy 18	1		
Cardiac Anomaly	3		
Ompholocele	1		
Gastroschisis	1		
Prematurity - Immaturity - Premature Labor - Premature Rupt. BOW			16
Incompetent Cervix			6
Diabetes			3
Preeclampsia, severe			2
Other include ---	Auto accident, footling breech, anoxia, natural causes, ruptured fetal hepatic vein with intra-abdominal hemorrhagea, cystic hygroma, Rh sensitized, aspiration of meconium		

Summary & Comments

The 1981 statistics for stillborns have been presented and compared with the previously published 1980 data. There was a marked increase in the 30 to 34 age group for stillborns but the numbers are small and may not be significant. Continued survey will give a more realistic picture which will also be true for the increase in numbers for the teenage pregnancy and the decrease in the 35 and older age group. Cord involvement was the most frequent reason given for the stillborn when fetal demise occurred during delivery. Continuous fetal monitoring until the delivery of the infant is essential. The new category "Fetal Distress" as a reason for C-section, and the finding at the time of delivery, of degenerative changes indicating earlier fetal demise, points out the need for more accurate methods to determine in-utero fetal death.

The autopsy percent decreased in 1981. Reports varied from very detailed to reporting an inability to examine because of degenerative changes. The findings reported in the majority of autopsies did not help or change the diagnostic impression as to the cause of fetal demise. A need for more consistent guidelines for stillborn investigation is evident.

As in 1980, the recommendation to appoint a committee to develop criteria for post stillborn workup still exists. This information would be educational as well as a tool for data collection. Gathered information could be pooled and hopefully insight developed that would reduce the stillborn rate for our state.

Cooperative efforts between the Maternal and Child Health Committee of the Nebraska State Medical Society, the Nebraska State Perinatal Society and the Maternal and Child Health Division of the State Health Department, could create an AD HOC Committee to set standards for examination of stillborns and review information presented. From this data suggestions should be forthcoming to decrease the stillborn rate. The committee should include a Pathologist, Geneticist, Obstetrician, Pediatrician and Family Practitioner.

BRIEF COMMUNICATION

The Efficacy of Androgen Deprivation in the Management of Stage D-2 Adenocarcinoma of the Prostate

ALAN H. DOMINA, M.D.
Lincoln, NE

DISSEMINATED adenocarcinoma of the prostate (stage D2) has an ominous prognosis. Schoonees, Palma et al[1] report an average survival of 1.7 years. According to Nesbit and Plumb,[2] the overwhelming majority of untreated patients with stage D2 disease die within one year. White, Paulsen and Glenn[3] found a 9% survival at 10 years with therapy, orchiectomy being the therapy of choice. DeKernion[4] recommended early orchiectomy as the treatment of choice in stage D2 patients. Presented here is a patient so treated with rather remarkable results.

P.F., a 53 year old Caucasian, presented with complaints of lower abdominal discomfort as well as obstructive urinary symptoms. A huge mass was noted on digital rectal exam. Laboratory studies revealed an acid phosphatase of 8.16 units (normal below 0.6), a normal chem profile with the exception of a total bilirubin of 2.3 mg/dl with 0.3 direct and 2.0 indirect. Extensive metastases to the lungs were noted on the chest x-rays. An intravenous urogram illustrated normal upper tracts with a huge prostate distorting the base of the bladder with marked "J" deformity of the distal ureters and osteoblastic activity in both ischial spines. A barium enema revealed diverticulosis with some bowel compression by the pelvic mass. Bone and liver scans were considered normal, as was an oral cholecystogram. A transrectal needle biopsy of the prostate was reported as "poorly differentiated adenocarcinoma." Cystoscopy was attempted, but could not be completed due to the length of the prostatic urethra. Urethral catheter drainage was instituted and bilateral orchiectomy was performed. He was also treated with oral diethylstilbestrol 1 mg. per day.

Two weeks postoperatively he was voiding quite well without catheter assistance. His serum acid phosphatase was 2.52 units. Six months later his chest film, acid phosphatase, serum creatinine and urinalysis were all within normal limits. He was re-evaluated periodically and after 6 years the diethylstilbestrol was discontinued. Seven and one-half years after diagnosis he remains a healthy, active man with no evidence of disease noted on chest films, serum acid phosphatase, chem profile and digital rectal exam. He underwent cholecystectomy for cholelithiasis and had no evidence of metastatic disease at that exploration. He is on no therapy and will be re-evaluated twice yearly.

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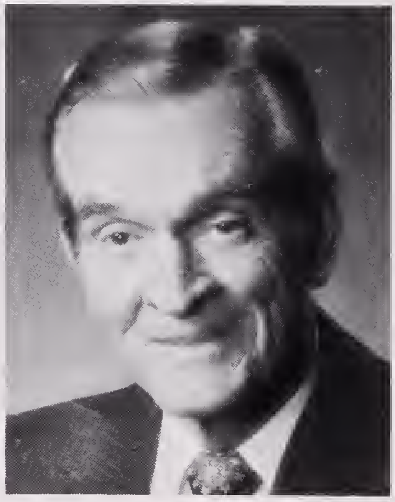
President's Page

PROFESSIONALISM


Francis D. Donahue, M.D.

Today one of the pervasive concerns expressed in medical circles is the fate of our professionalism. This term as applied to medicine illustrates how this profession not only differs from others by its being unique but as an antithesis to a trade (buying and selling).

The basic elements of this professionalism are autonomy, compassion, and the unique expertise of its practitioners. Today the rapid and drastic changes in medicine are finding many physicians faced with constraints and regulations from many quarters. Many will be employed or closely associated with governmental agencies, major corporations, various forms of health care delivery systems, proprietary enterprises and will experience pressure by administrators, and assorted gatekeepers who must ensure a profit. These factors could easily pressure some to yield their traditional autonomy and urge them to accept an ethic totally devoid of any semblance of compassion with profit their only goal.

Down through the years the public has trusted the profession to work conscientiously without supervision. They felt the physicians had the unique skills and knowledge the non-medics did not possess, hence they could be trusted to not only regulate their members but produce, without supervision, a high standard of health care. Increasingly we note groups who indeed feel they have the medical knowledge and sophistication that qualify them to not only evaluate the physicians' performance and regulate practitioners, but to lay claim they should be the advocates of the sick and are better equipped to direct health care.

If we are to preserve our perception of professionalism the task will not be easy. We must above all else insist in spite of growing opposition, to maintain a high degree health care quality. Along with this, proper standards of discipline must be maintained that will be deserving of the public's trust. Accompanying this must be a concern for costs and a genuine compassion particularly for the poor and elderly.

Alexander Pope, brilliant 18th Century poet, paid a great compliment to his personal physician and good friend, Doctor Arbuthnot, in the lines paying tribute to his being a professional and not a tradesman.

"Removed from kind Arbuthnot's aid
who knows his art but not the trade."

We have inherited this legacy from these going before us and have a solemn duty to pass it on to those following.

Francis D. Donahue, M.D.
President

Welcome New Members

John J. Edney, M.D.
7710 Mercy Rd., #609
Omaha, NE 68124

Larry Eggert, M.D.
UNMC - Room 4311
Omaha, NE 68105

Robert M. Langdon, Jr., M.D.
8300 Dodge St.
Omaha, NE 68114

James V. Ortman, M.D. (reinstated)
628 Professional Tower
Omaha, NE 68102

Kay Ticen, M.D. (reinstated)
908 Martin Dr., W
Bellevue, NE 68005

Leo F. Weiler, M.D.
Burwell, NE 68823

In Memoriam

> *By medicine life may be prolong'd*
> *yet death*
>
> *Will seize the doctor too.*
>
> *—Shakespeare*

W. Ray Hill, M.D. — (Born June 22, 1904 - died April 20, 1985) — Medical Specialty — General Practice. Doctor Hill was a graduate of the University of Nebraska College of Medicine in 1938 and practiced in Seward, Nebraska until his retirement. He was a member of the Nebraska Medical Association and the American Medical Association.

The Auxiliary

CONVENTION 1985

The Nebraska Medical Association Auxiliary met at the Cornhusker Hotel in Lincoln, celebrating their 60th annual meeting.

Annual Board Meeting chaired by President Helen Krause started the 3 day gathering of the Nebraska auxiliary.

A luncheon, welcoming all, was held at the Cornhusker followed by a Seminar "Calling the Shots, The Advertising of Alcohol" by Becky Beardsley from the Lincoln Council on Alcohol and Drugs.

Friday evening a progressive dinner was enjoyed with gracious hosts, Mrs. George Gammel and Mrs. L. Palmer Johnson opening their homes for our enjoyment. Many thanks to these ladies and the Lancaster County Auxiliaries who worked to make this such a pleasant evening.

Saturday, guest speaker at our Awards Brunch was Billie Brady (Mrs. Wayne C.), President of the American Medical Association Auxiliary.

Billie who is from Greenville, South Carolina was elected president-elect at the AMA Auxiliary Convention in June 1983, and took office as president at the 1984 Convention. She has been active on the national level since 1975, holding many positions.

We were honored to have Billie with us to encourage continued activity by our State Auxiliary, to increase membership and to establish a good working relationship with our Nebraska Medical Association. She reminded us of the importance of our volunteerism in our communities, especially concerning health projects.

It was a privilege to have her install our new officers. During our awards luncheon it was a highlight to hear the names of our "Woman of the Year" who is Helen Mahon, Norfolk and "Merit Award" winner, Jane Taylor of North Platte.

How thrilling to listen to the list of their activities and achievements and know they are a part of the organization, and to know we are achieving its purposes which are:

To assist in these programs of the American Medical Association that improve the health and quality of life for all people; to promote health education; to encourage participation of volunteers in activities that meet health needs; and to support health related charitable endeavors.

Donna Stone, our very busy A.M.A.E.R.F. chairman, thrilled us all with her $7,181.45 total contributions. This is an increase of $1,535.48 over the previous year. If you did not buy a loaf of her homemade bread (all monies going to A.M.A.E.R.F.) you missed out on a special treat. Leading contributor was Lancaster County.

Colleen Adam, Nebraska Medical Foundation chairman, announced contributions amounting to $2,859.08.

It was a joy to have as special guests our Past Presidents Mrs. J. Whitney Kelley (Irene), Mrs. Fay Smith (Jo), Mrs. Robert McIntire (Marilyn), Mrs. Leland Olson (Dorothy), Mrs. James Carlson (Barb), Mrs. Warren Bosley (Alleen), Mrs. Y. Scott Moore (Patsy), Mrs. Gordon Francis (Harriette), Mrs. Guy Matson (Dodie), Mrs. Harry Shaffer (Dorothy), Mrs. Clifford Hadley (Beth), Mrs. L. Palmer Johnson (Shirley), Mrs. Bryce Shopp (Wanda), and Mrs. Glen Lau (Ella).

What a privilege to hand on the gavel to my dear friend and your new president Ardis Grace.

We have been striving to carry out the objectives of our auxiliary one which states "A spirit of friendliness among physicians' families." Our annual meeting is an opportune time to renew and make new friendships.

Making friends and meeting people has been my bonus as Nebraska Medical Association Auxiliary President and I thank you, the members, for the privilege.

Respectfully,
Helen J. Krause

O'Donohue New C.U. Chairman of Medicine

Dr. Walter O'Donohue Jr. has been appointed chairman of the department of medicine at the Creighton medical school by Dean Richard O'Brien, effective June 15.

Dr. O'Donohue has been professor of medicine and director of pulmonary medicine since joining the Creighton faculty in 1977. He also will serve as chief of internal medicine on the Saint Joseph Hospital staff.

He succeeds Dr. George Clifford, chairman of the department of medicine since 1972, who will be devoting full time to teaching and research responsibilities in his position as professor of medicine.

Dr. O'Donohue is a graduate of the Medical College of Virginia, where he also served his residency in medicine and a National Institutes of Health research fellowship in pulmonary and cardiovascular medicine. A fellowship in endocrinology at the Massachusetts General Hospital, Harvard Medical Service, was interrupted in 1963 when he was called to active duty in the Army Medical Corps.

Dr. Walter O'Donohue Jr.

He also has served as medical director of Creighton's respiratory therapy educational program since 1980, and as chairman of the Saint Joseph Hospital Medical Policy Board from 1979 to 1982.

Coming Meetings

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

TETON'S GENERAL PEDIATRIC CONFERENCE — June 30 - July 6, 1985. Sponsor: Department of Pediatrics, University of Nebraska College of Medicine. Location: Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 20 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Pediatric cardiology, gasteronterology, genetics, asthma, allergies and immunology, neonatology, nutrition and eating disorders. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

TETON'S SPORTS MEDICINE CONFERENCE — July 7-11, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: Conference Center, Jackson Hole Racquet Club, Jackson, Wyoming. Credit: 16 Hours AMA Category I and AAFP Prescribed. Fee: $275 Physicians, $175 Residents in Training. Topics: Current concepts on evaluation, conditioning, management and rehabilitation of the recreational and competitive athlete as well as use of exercise therapy in a variety of medical problems and injuries. Contact: Marjorie Adey, Coordinator, Continuing Medical Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, NE 68105, (402) 559-4152.

LAKE OKOBOJI SPORTS MEDICINE CONFERENCE, "THE YOUNG ATHLETE" — July 24-27, 1985. Sponsor: Section of Sports Medicine, Department of Orthopaedic Surgery & Rehabilitation, University of Nebraska College of Medicine. Location: The New Inn Conference Center, The New Inn Lodge, Okoboji, Iowa. Credit: 12½ Hours AMA Category I and AAFP Prescribed. Fee: $150 physicians, $75 residents in training & students. Topics: Identification and management of sports related injuries, current concepts on nutrition and the care of the young athlete with medical problems. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — DR. JOHN S. LATTA CENTENNIAL LECTURESHIP — August 29-30, 1985, UN Medical Center, Omaha, Nebr. Speaker: Dennis G. Osmond, M.B., Ch.B., D.Sc., F.R.S.C., the Robert Reford Professor of Anatomy at McGill University, Montreal, Quebec. Thursday, August 29 — Latta Lecture: "Understanding the Immune System: Changing Perspectives" — 12 noon, UNMC campus. Friday, August 30 — Medical Grand Rounds: "The Contribution of the Bone Marrow to the Immune System: B Lymphocyte Production, Differentiation, Localization and Regulation" — 12 noon, Bishop Clarkson Hospital, Storz Pavilion, Omaha, Neb. Everyone invited.

EMERGENCY MEDICINE REVIEW — September 23-28, 1985 and will be repeated on October 1-12, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. Credit: 45 hours AMA Category I, AAFP Prescribed & ACEP Category I. Fee: $425 physicians, $325 residents in training. Content: This course will provide physicians engaged in the evaluation and treatment of urgent and life threatening conditions with an in-depth review of emergency medicine. Special attention will be given to the recognition of conditions that must be identified immediately, and evaluation of nonemergency conditions. Daily national board type exams will be given. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Cocktail Reception — Friday, October 11, 1985, 5:30-7:00 p.m., in conjunction with the American Academy of Family Physicians Meeting, Marriott Hotel, Anaheim, California. All alumni, spouses and friends are invited. Cash bar.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Roundup and Reception in Omaha, Monday, October 28, 1985, 6:00-7:00 p.m., Red Lion Inn Ballroom; in conjunction with the Omaha Mid-West Clinical Society Postgraduate Assembly. Cash bar. All alumni, spouses, faculty and friends are cordially invited. Followed at 7:45 p.m. with 50-year dinner in Nebraska Room, Red Lion Inn. Class reunions will be held in Omaha at the end of October for classes ending in “5” and “0”.

CREIGHTON UNIVERSITY

FAMILY MEDICINE UPDATE — Aug. 30-31, Sept. 1, 1985, The Lodge at Okoboji, Okoboji, Iowa. Program Director: Fred J. Pettid, M.D., Department of Family Practice, Creighton University. Topics include office cardiology, high risk obstetrics, office urological problems, dermatology, and medical-legal issues. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

HEART AND MIND — Oct. 10-12, 1985, Marriott’s Tan-Tar-A Resort, Lake of the Ozarks, Osage Beach, Missouri. Program Directors: Emmet M. Kenney, M.D. and Syed M. Mohiuddin, M.D. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

GYNECOLOGIC MALIGNANCIES — Sept. 27, 1985, Boystown National Institute Auditorium, Omaha, Nebraska. Co-sponsored by the departments of medicine, surgery, obstetrics and gynecology and Saint Joseph Hospital for primary care physicians, general surgeons, gynecologists, and nursing personnel. Program Director: James A. Mailliard, M.D., Division of Oncology, Creighton University. For information: Division of CME, Creighton University.

ANGIOPLASTY — Aug. 10, 1985, Room 6712, Saint Joseph Hospital, Omaha, Nebraska. Creighton Premiere Rounds, 8:00-9:00 A.M.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

HEART AND MIND: NEUROCARDIOLOGY UPDATE — September 7, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

ANNUAL SURGERY SYMPOSIUM — September 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

KANSAS CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS MEETING — September 14-15, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — September 19-20, 1985, November 14-15, 1985. Sponsor: University of Kansas Medical Center, Department of Otorhinolaryngology. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA Category I. Fees: $625. Maximum Enrollment: 9 persons per session.

MEDICINE AND RELIGION: The Supreme Being, the Supreme Court, and the Almighty Dollar — October 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Target Audience: Physicians, Nurses, Clergy, Social Workers, Nursing Home Administrators. Contact: Promotion Coordinator, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4488.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

2ND MIDWEST REGIONAL CONFERENCE ON WOMEN IN MEDICINE — September 27, 28, and 29, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri. Credit: 8 hrs. AMA Category I, 8 hrs. AAFP. Fees: $130 Physicians, $60 Other Health Professionals, $20 Students. Guest Speaker: Ellen L. Shulman, M.D., NASA, Lyndon B. Johnson Space Center, Houston, Texas.

ANNUAL INTERNAL MEDICINE SYMPOSIUM — October 9, 10, 11, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

53RD ANNUAL POSTGRADUATE ASSEMBLY — Omaha Mid-West Clinical Society, October 28, 29, 30, 1985, The Red Lion Inn, Omaha. For information contact Miss Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 7363 Pacific Street, #205-B, Omaha, Nebraska 68114.

Picture Gallery

1985 Nebraska Medical Association Annual Session

Dr. Jerald Schenken addressing the House of Delegates.

Mrs. Helen Krause presenting AMA-ERF check to Dr. Michael Haller, Creighton University School of Medicine.

Medicine & Religion Luncheon

Mrs. Helen Krause presenting AMA-ERF check to Dr. Harry McFadden, University of Nebraska College of Medicine.

Dr. Howard Dinsdale presenting Nebraska Medical Foundation Student Research Scholarship check to Sheri Nottestad, Creighton University School of Medicine.

Dr. Howard Dinsdale presenting Nebraska Medical Foundation Student Research Scholarship check to Donald Jacobs, University of Nebraska College of Medicine.

Mrs. Helen Krause addressing the House of Delegates.

Mr. Michael Dugan, Director, Department of Insurance, addressing the House of Delegates.

Dr. James Dunlap addressing the House of Delegates.

Dr. Russell Gorthey addressing the House of Delegates

Dr. Richard Meissner addressing the House of Delegates.

Mr. Luke Lemke presenting an award to Dr. Frederick Paustian.

Dr. F. Wm. Karrer addressing the House of Delegates.

Dr. Francis Donahue addressing the House of Delegates.

Dr. John Coe addressing the House of Delegates.

Dr. Gary Smith presenting Nominating Committee report.

Dr. Herbert Reese escorting 1985-86 President-Elect, Dr. Hiram Walker to the podium.

Dr. Paul Collicott presiding at the Inaugural Banquet.

Dr. Herbert Reese presenting Dr. Hiram Walker with President-Elect badge.

Drs. Herbert Reese, Francis Donahue and Paul Collicott.

Dr. Hiram Walker addressing the House of Delegates.

Dr. Herbert Reese presenting President's badge to Dr. Francis Donahue.

1985 Inaugural Banquet

Dr. Herbert Reese presenting gavel to Dr. Francis Donahue.

Dr. Herbert Reese presenting President's Medallion to Dr. Francis Donahue.

Dr. Herbert Reese congratulating Dr. Francis Donahue, 1985-86 NMA President.

Dr. Herbert Reese presenting "It's Only a Pumpkin" plaque to Dr. Francis Donahue.

Dr. Francis Donahue addressing the Inaugural Banquet.

Dr. Francis Donahue presenting Past President's badge to Dr. Herbert Reese.

Dr. Joseph Boyle, AMA President, addressing the Inaugural Banquet.

Dr. Francis Donahue presenting plaque to Dr. Herbert Reese.

Dr. Joseph Boyle, AMA President, addressing the Inaugural Banquet.

REPORTS OF OFFICERS, DELEGATES AND COMMITTEES

ANNUAL SESSION

April 26, 27 and 28, 1985

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports.)

REPORT OF THE BOARD OF DIRECTORS

Herbert E. Reese, M.D., Lincoln - Chairman; Francis Donahue, M.D., Omaha; Robert Shapiro, M.D., Lincoln; Dwaine Peetz, M.D., Neligh; Donald J. Pavelka, M.D., Omaha; L. D. Cherry, M.D., Lincoln; Hiram Walker, M.D., Kearney; Alvin Armstrong, M.D., Scottsbluff; Harry W. McFadden, M.D., Omaha; Stanley M. Truhlsen, M.D., Omaha.

(1) Several physicians have contacted the Association office regarding letters being distributed by American Family Insurance pertaining to physicians' fees. The Board decided to have the matter reviewed by legal counsel for clarification of how Nebraska insurance statutes relate to the activities being carried on by the insurance company.

(2) The Board discussed the possibility of utilizing a membership survey through the Select Research Inc. (SRI) company. A survey was carried out and the responses are being provided to various Association commissions and committees for review.

(3) The Board approved the development of an Associate Member category in the By-Laws for physicians who retire from practice prior to being eligible for Life Membership under the existing criteria. The Board recommended this category provide for the physicians to receive the mailings of the NMA at a determined charge. These two recommendations were referred to the Commission on Association Affairs for consideration.

(4) The Board discussed the feasibility of reducing dues for husband/wife members but determined that for the present, such action was not necessary.

(5) The Board reviewed the resolution adopted at the 1984 Fall Session which proposed that member benefits be studied by an appropriate commission of the Association. The resolution was referred to the Commission on Association Affairs and several activities are underway through subcommittees developed by that Commission.

(6) The Board considered the matter of determining whether Life Members should be asked to pay a nominal fee for a subscription to the **Nebraska Medical Journal** and other NMA publications. The approximate cost of providing the Journal and all mailings to each member is $20 per year. The consensus of the Board was that the Life Members could be surveyed and asked if they wanted to receive the Journal and other mailings, however, no fee should be charged. The matter was referred to the Commission on Association Affairs with the suggestion that Life Members be surveyed to determine their interest in receiving the Journal and other mailings eminating from the Association office.

(7) The Board considered the recommendation of the Fall Session Reference Committee which suggested that the function of monitoring quality and doing professional review for the PRO not be performed by the same committee. This matter was referred to the Commission on Association Affairs for further study.

(8) The Association received word in October, 1984, that the criteria had been met and the NMA would be awarded a third delegate for the December, 1984, AMA meeting. The Board selected Louis J. Gogela, M.D. of Lincoln, an Alternate Delegate to the AMA, to serve as the third delegate for the December meeting. The Board then referred the matter to the Commission on Association Affairs with the directive to provide the House of Delegates with a report and recommendation concerning the selection of the third AMA delegate in future years when the membership criteria is met. Appropriate recommendations for amendments in the By-Laws are being presented at this Annual Session.

The American Medical Association has notified the Association office that we have achieved the third delegate status for both AMA House of Delegates meetings in 1985. The criteria is basically that 75% of Nebraska Medical Association members also be members of the American Medical Association.

(9) The Board considered the possibility of reinstating a registration fee for the Annual Session. It was noted that the scientific portions of the program basically pay for themselves through grants and participation fees assessed each organization that takes part in producing the Annual Session. The Board decided that a nominal registration fee would greatly assist in relieving costs currently being covered by the budget. It was decided to initiate a $20 pre-session registration fee and a $25 fee if registering at the session. The registration fee will be implemented in two categories. Category I would be a CME registration fee which would include a certificate being issued following the Annual Session. Category II would carry no charge and would be considered a business session only category.

(10) Doctor Jerald Schenken announced his intent to seek election to the AMA Board of Trustees following the December, 1984, meeting of the AMA House of Delegates. The North Central Medical Conference is working diligently to achieve Doctor Schenken's election at the June, 1985, session of the AMA. The Nebraska Medical Association is conducting the campaign and the Board approved a financial contribution of up to $5,000 from the special funds account to assist in covering the cost of the election.

(11) As part of the Boards long range planning activity, we herewith submit a series of recommended goals and objectives to be applied as guidelines for the future direction of the NMA. It is felt the revised mechanism will better utilize and also serve all members of the Nebraska Medical Association. These items will be under regular review to insure the continued flexibility of the Association to meet new issues as they come to the forefront.

OUTLINE

Nebraska Medical Association's Purposes, Goals and Initiatives

A. Preamble

This last year has produced a remarkable change in the environment of medical practice in Nebraska. Although this change was not unforeseen with the national changes that have been occurring over the last several years, the rapidity of the change and the diversification of the delivery system in Nebraska, however, was not foreseen. Health care issues have had unprecedented attention from the public, government and the media. With these wide-spread changes and the attention they have received, it is imperative for the Nebraska Medical Association to re-examine its purposes and its ability to face the challenges ahead.

B. Purposes

The purposes of the Nebraska Medical Association were re-examined. The purposes of the Association as revised in the By-Laws of 1978 are:

1. to advance the science and art of medicine
2. to elevate the standard of medical education
3. to promote individual wellness and improve public health
4. to disseminate to its members and others facts and opinions related to medical knowledge, treatment and procedures
5. to provide a vehicle for fellowship among those engaged in the practice of medicine in the State of Nebraska
6. to provide for an association of Nebraska physicians to cooperate with the American Medical Association in appropriate areas
7. to monitor proposed legislation and to provide facts and opinions to state government officials on matters pertaining to public health and to the interest of its members.

The purposes are enlightening, broad and encompassing requiring no apparent change.

C. Goals and Initiatives

In order to accomplish the purpose of the Nebraska Medical Association, four precise goals have been defined to meet the challenges ahead. Along with each goal high priority initiatives to accomplish these goals are defined. These four major goals of the association are related to its responsibilities to the profession and the public. They are:

1. Representation of the medical profession

The Nebraska Medical Association's most important purpose is to serve as the vehicle for the representation of the medical profession on a local, state and national level. Physicians have a moral responsibility to advocate in the best interest of their patients. Their professional organizations have a similar duty to meet that responsibility in a truly concerted manner. This representation must be consistent with the additional responsibility to act in the best interest of the public. High priority initiatives are:

a. Legislative Representation

The Nebraska Medical Association must develop a strong advocacy in the legislative and regulatory arena both locally and nationally in concert with the entire federation of organized medicine.

b. Medical Service Representation

The Nebraska Medical Association must be a vehicle for the representation of the profession in their advocacy of patient interests as changing relationships are developed with hospitals, the public, third party payors, business, health care coalitions, for profit organizations and corporate medicine.

c. Manpower

The Nebraska Medical Association study and recommend regarding health care manpower of the State of Nebraska to include all other practitioners and ancillary care providers.

d. Professional Liability

The Nebraska Medical Association must continue its efforts in the professional liability arena in order that physicians can provide high quality medical care without fear of undue liability exposure and that actual negligence can be fairly and efficiently compensated.

2. Provision of information

With the rapid changes, the association must provide reliable information to matters concerning the profession both scientific and socio-economic. With the expanded economic forces, socio-economic information to the physician and to the public will be necessitated. High priority initiatives are:

a. Medical Practice Information

The Nebraska Medical Association needs to expand, collect, analyze and disseminate information related to medical practice in the State of Nebraska.

b. Interprofessional Communication

With the rapidity of change, the Nebraska Medical Association needs to tie in with the federation by computer network and develop a local network for rapid dissemination of pertinent information to its members.

c. Public Information

The Nebraska Medical Association needs to develop and disseminate in concert with the activities of the American Medical Association, public information regarding medicine and its delivery.

3. Establishment and maintenance of standards of conduct and performance

The growing diversification in health care delivery will intensify the pressures on all physicians to uphold the highest standards of professional conduct while administrating quality care in a cost effective manner. The Nebraska Medical Association using national guidelines and with local variations must provide guidelines for physicians in the professional conduct and performance of their practice.

High priority initiatives are:

a. Quality Assurance

The Association has to be active in the preservation of quality of care and the physician advocacy for the patient.

b. Interprofessional Code of Ethics

The Association has to be active in the development of a code of ethics of physician inner relationships in the changing economic environment.

c. Professional Code of Ethics

The Association needs to be active in the development and maintenance of standards regarding physician relationships with hospitals, alternative delivery systems, health care coalitions and business.

d. Ethics of Rationing

The Association needs to study and respond to the physician's increasing role in resource allocation.

e. Physician Discipline

The Association needs to review and define the spectrum of physician disciplinary actions.

f. Indigent Patient Care

The Association needs to define and respond to the needs of the increasing number of indigents.

4. Membership and membership benefits

The purposes of all medical societies are in some way related to enabling physicians to provide quality of care to their patients. With medicine's changing environment, adequate representation information and standards can only be developed with active membership. Never before has membership been so important individually and collectively in order to be recognized as a profession with standards. In order to accomplish medicine's goals, active membership locally and nationally must be sought. Benefits must be attractive and reasonable for the membership.

High priority initiatives:

a. Membership Recruitment

Membership recruitment to assure the physicians retain their abilities as a profession, issues must be dealt with on local, state and national levels requiring membership at all three levels.

b. Membership Benefits

Other than some of the intangible benefits, there is a need for more tangible benefits to members. These tangible benefits fall in three distinct areas: insurance and financial, benefits related to medical practice, and other tangible benefits.

1. Financial and insurance would include comprehensive insurance plan, retirement benefits, etc.
2. Related to medical practices-marketing services, office management services, practice analysis, computer services, etc.
3. Other benefits — group purchasing, gold cards, leisure and travel, etc.

The Nebraska Medical Association needs to study, define and recommend in concert with experts and the federation regarding distinct member benefits.

c. Association Revenues

Utilize income generated from making these benefits available, to hold down association dues in order to further enhance desirability of association membership.

D. Organization to Accomplish Goals

The Board of Directors of the Nebraska Medical Association makes the following proposal for restructuring of NMA Commissions and Committees. It was felt the Commissions should be streamlined in order to maintain Association activities under a cohesive mechanism. It is felt subcommittees could function under the Commissions, however, all free-standing committees should cease to exist as such. It was felt all Commissions need to be active and functioning in order for them to continue to be effective. The Commissions would function as task forces to develop the initiatives abdicating to subcommittees for specific work activities. The Board proposes all ad-hoc committees and free-standing committees be placed under one of the following six Commissions. The Board has proposed the additional activities be considered by each Commission.

(1) Commission on Association Affairs
  a. Manpower
  b. Member benefits
  c. Membership
  d. Association Revenues
  e. Computers
  f. Scientific Sessions

(2) Commission on Medical Services

The activities of this Commission would be broadened from its previous activities as well as a change in name of the Commission from the Commission on Clinical Medicine to the Commission on Medical Services to reflect broadened activities.

  a. Quality assurance
  b. Standards and ethics of the profession
  c. Alternate delivery systems
  d. Physician inter-relationships
  e. Pricing mechanism
  f. Indigent care
  g. Wellness
  h. Business coalitions

(3) Commission on Legislation and Governmental Affairs

It has been recommended that the Commission on Legislation and the Governmental Affairs be combined and be called the Commission on Legislation and Governmental Affairs.

  a. Monitoring of national activities
  b. State legislative activities
  c. Political awareness
  d. Professional liability
  e. Professional discipline

(4) Commission on Medical Education
  a. CME
  b. Medical school liaison

(5) Commission on Public Affairs
  a. Communication - public and within Association
  b. inter-professional communication

(6) Commission on Hospital Medical Staff
  a. M.D./hospital relationships
  b. Resources for such things as joint ventures, free-standing clinics, surgicenters, networking, etc.
  c. Be a resource for informational materials

MEMBERSHIP

	1985 **As of 4/12/85**	**1984** **As of 12/31/84**
NMA Active	1419	1512
AMA Active	938	1039
NMA Students	89	134
NMA House Officers	4	8

REPORT OF THE DELEGATE TO THE A.M.A., INTERIM MEETING

The 1984 interim meeting of the AMA House of Delegates met in Honolulu, December 2-5, 1984.

The AMA meeting in Honolulu was attended by 367 delegates. 293 of these represented state medical societies, 65 represented national medical specialty societies, and section and service delegates representing the armed services and physicians in training.

There were two new societies granted voting seats in the House of Delegates. These were the American Group Practice Association and the American College of Legal Medicine.

The keynote of the convention was sounded by the presidential address of Dr. Joseph Boyle, the current AMA President, who pointed out that organized medicine must oppose Reagan Administration efforts to further cut health care spending. He stated "Enough is enough," and stated the AMA could generate more enthusiasm and cooperation from its members without the kinds of remedies that the Administration and Congress have been dispensing.

The delegates then considered 78 reports and 109 resolutions. In addition to the Nebraska resolution, I have discussed in some detail several of the more important matters.

(1) NEBRASKA RESOLUTIONS

The Nebraska delegation submitted four resolutions, and Dr. Cornelius submitted an individual resolution.

Resolution #5 dealt with the membership benefits of the AMA. It pointed out that those physicians who realize the importance of AMA membership are already members, but that the recruitment of new members will take salesmanship. The Resolution then demanded that the AMA develop a list of membership benefits that have already accrued to members — and that further, the benefits which accrue only to members be pointed out. After appropriate discussion, this was referred to the Board of Trustees.

Resolution #4 asked that the AMA point out to the Food and Drug Administration that many years of exclusive patent time are used up by the FDA before final release of new drugs on the market. It then recommended that (1) patent exclusive time start on the day FDA releases the drug for marketing, (2) generic drugs be dispensed with the name of the manufacture on the label, and (3) the printout which is sent out with every drug include a percentage of bioactivity compared to the original drug. This was referred to the Board of Trustees by the Reference Committee.

Resolution #6 stated that while second opinions have frequently been used in consultation, they now are being more frequently requested by patients, insurance carriers, and employers. A request for a second opinion not initiated by the attending physician creates new interprofessional relationships between physicians that are not well understood. There was a similar type resolution from Oregon which addressed the same subject — and the Reference Committee dealt with both resolutions at the same time.

They then adopted the following Substitute Resolution in lieu of the two resolutions proposed. They resolved, that the AMA study the professional and ethical aspects of second opinion programs and procedures for their implementation. They also will investigate the problem of multiple authorizations for second opinion schemes, and will try and propose the carrier objectives while alleviating the confusion now facing physicians and their office staffs. This Substitute Resolution was then adopted which essentially accomplished what Nebraska wanted.

Resolution #7 recognized that it is important to develop physician interest and expertise in the problems of legislation, and regulation in health care financing. The Resolution recommended that the AMA study the desirability and feasibility of developing a program of Congressional Fellows for physicians in health care funded and administered by the AMA. This was adopted and hopefully the recommendations will be implemented.

Resolution #39 was offered by Dr. Cornelius, and this discussed Peer Review and asked the AMA to study the influence of Peer Review Organization goals on care provided to Medicare beneficiaries. This was dealt with by the Reference Committee in conjunction with an additional four resolutions dealing with the same type of concern. The House then adopted a Substitute Resolution in lieu of these five submitted resolutions which resolved, that the AMA continue its support for professionally directed programs of medical peer review, to actively oppose the HCFA continued use of arbitrary admission and quality objectives. They also suggested implementing a PRO monitoring system to redress PRO problems through regulatory and legislative means.

(2) BOXING

The action of the House of Delegates which really captured the attention of the press was the ban on boxing. During their deliberations, the House considered four resolutions calling for opposition to the sport of boxing. These resolutions were widely supported and presented by California, District of Columbia, the American Academy of Pediatrics and the American Academy of Neurology.

The House concluded that despite some positive aspects of the sport, the American public is best served by the AMA's opposition to boxing at all levels. They encouraged the elimination of both amateur and professional boxing, a sport in which the primary object is to inflict injury. To communicate the opposition to boxing to all regulating bodies, to work with state medical societies and their legislatures to enact laws to eliminate boxing, and to educate the public, especially children and young adults in the dangerous effects of boxing.

The floor debate was swift and short, and although there were suggestions that more study might be required, the suggestion was rejected and the House adopted a policy against boxing.

(3) PUBLIC IMAGE OF PHYSICIANS

The delegates voiced great concern over negative public opinion against physicians. There were two resolutions submitted, one from Ohio and one from Oklahoma, and these along with the Board of Trustees Report OO dealt with the problem.

The Oklahoma resolution called for the AMA to retain consultants and undertake a national public relations campaign to improve the image of physicians.

The Ohio resolution called for the AMA to develop a national public information program in current health care delivery items.

Report OO of the Board of Trustees described the current AMA activities relating to the public communication and cited the difficulties of changing public perception, and outlined potential future activities to enhance the public image of the individual M.D. and the profession, along with the AMA.

There was considerable feeling among the delegates in support of these two resolutions, and some concern that Report OO had not adequately addressed the problem.

The Reference Committee recognized the considerable costs associated with national publicity campaigns, and the lack of evidence of their effectiveness. Hence, they proposed a focused short term effort combined with the development of a long range plan, and a report on its effectiveness to be submitted to the House of Delegates at the 1985 Annual Meeting.

At the time of the Reference Committee meeting, Dr. John Coury, Chairman of the Board of Trustees, testified against the Oklahoma and Ohio resolutions and urged support and adoption of the Board of Trustees Report OO. He stated that the Board is hearing the message, and in his judgement, the AMA is at the present time effectivley projecting our image. Almost each meeting deals with this same plea for a more effective public relations campaign.

Finally, a Substitute Resolution was adopted, along with the Board of Trustees report. It was my impression that once again, we were unable to adequately get a handle on the problem. However, if we keep this problem in the forefront, we will eventually resolve it in some manner.

(4) UNIFIED MEMBERSHIP

Although there are now only two unified states as regards membership, the idea still holds considerable appeal. And of course, just a few short years ago unified membership was universal in that one needed to belong to all three levels to maintain membership.

There is no question but that the cost of dues is the major cause of non-unification. The AMA has approved a 10% discount to members who belong to a unified society. This was conceived as an inducement to retain all memberships.

In addition to the discount, the AMA would also provide staff services for social projects, provide special briefings for officers of the unified societies, and provide a higher reimbursement rate to constituent societies for dues collection.

In addition to this dues adjustment, the House of Delegates adopted a report which will revise the option of processing memberships, and by 1986 will allow for installment payments of dues. This may require some changes in state policy to fit with this new concept of payment. This change resulted from a study which revealed that 17% of physicians said installment payment would favorably influence their decision to renew AMA membership. An additional 16% of non-members said it would influence them to join.

(5) FOREIGN MEDICAL GRADUATES

I have noted the problem of FMG's over the years in these reports, and because the influx of FMG's into the medical profession appears to have ebbed, an update on those previous reports seems to be indicated.

A report of the Council on Medical Education which was adopted by the House of Delegates credits the stricter immigration laws as having stabilized the rate of immigration of FMG's into the United States.

The Chairman of the Council, Frank A. Riddick, Jr., said the report was offered in response to some resolutions which suggested there were an excessive amount of aliens entering the USA through the exchange visitor program.

He states, that is not the case and that present immigration laws are so strict that they may eventually destroy the exchange visitor program.

Interesting to note, that between 1965 and 1976, the U.S. Immigration law provided preferential entry for FMG's seeking graduate medical education. As a result of these liberal immigration laws, FMG's provided a third of the growth in physician population during the 1970's.

At the present time, due to the changes in the federal immigration laws, the number of FMG's engaged in graduate medical education is at an all time low. However, according to a recent AMA survey, there were 111,161 FMG's in the USA in 1983.

So it becomes apparent, the problems attendant upon FMG's are still with us, but the corrective measures taken have improved the situation appreciably.

(6) CHELATION THERAPY

An item of information that attracted a great deal of notice by the lay press was chelation therapy. This was stimulated by the discussion following the adoption of a report formulated by the Council on Scientific Affairs.

Chelation by definition, is the combination of a drug with a metal to form a water soluble complex that can be excreted in the urine. It is an accepted method for removal of some heavy metals, and for enhancing the elimination of calcium in hypercalcemia.

There was an extensive review provided which showed there was no scientific documentation that the use of chelation therapy was effective in treating cardiovascular disease, atherosclerosis, rheumatoid arthritis, and cancer. The prospects of this type of therapy have provided no scientific studies to justify their claims to the contrary.

Whereas there seems to be little, if any, of this type of treatment in Nebraska, it is a matter for all of us to be aware of.

(7) STAFF COMPETITION AND JOINT VENTURES

One item which received less attention than it probably should have was brought to focus by the Hospital Medical Staff Section. They have become a very active member of the House and outlined the problems presented by the conflicts between the hospitals and the medical staff.

The subject which drew the greatest interest was the "joint venturing" wherein the hospitals and their medical staff join to form a more satisfactory and lucrative method of health care delivery. They wanted the AMA to endorse the concept that physicians could participate in joint ventures along with their own independent legal advice.

One of their concerns was that certain groups within a hospital staff are favored, and they actually form a joint venture with the hospital to the exclusion of other members of the staff. As a result, those excluded may set up their own joint venture in competition to the original group.

There were a couple of related subjects that had to do with hospital staff tensions involving the setting of medical staff by-laws, and the amount of time allowed for staff activities. As a result of this, the AMA instructed its commissioners on the Joint Commission on Accreditation of Hospitals to seek deletion of language in the JCAH standards which would allow the unilateral amendment of medical staff by-laws by hospital governing boards.

It struck me that this is the opening shot in the battle that will be fought between hospital staffs and hospital governing boards. Now with the decrease in bed occupancy, and the more stringent DRG requirements, hospitals are going to insist on more control of the method of practice by the hospital medical staff.

CONCLUSION

One of the more exciting things, as regards the Nebraska delegation, was the announcement of the candidacy of Dr. Jerald Schenken for the Board of Trustees. He certainly is eminently qualified, and we are all proud to endorse and support him.

A campaign for a small state is no easy undertaking, but with the help of all our members, along with the support of the North Central Medical Conference, and the College of American Pathologists, we are confident of his success.

This convention we were represented by three delegates, Dr. Carl Cornelius, Dr. Louis Gogela, and me. The extra delegate was achieved by our 75% membership in the AMA. The delegation which includes Dr. Blaine Roffman, along with Dr. Herbert Reese, are proud to represent the physicians of the State of Nebraska at this national forum.

Respectfully submitted,

John D. Coe, M.D.
Delegate to the AMA

REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

Since my last report to the House of Delegates, St.

Joseph Hospital, the primary teaching hospital for the health sciences at Creighton University, has been acquired by American Medical International, Inc. This affiliation will have an important impact in the fields of health care delivery, health science education and medical research in our region.

AMI continues to support the academic mission and programs of Creighton University. In addition, proceeds of the transaction are deposited in a foundation, the Health Future Foundation, income from which will be devoted to the enhancement of teaching and research programs at Creighton, as well as to defraying the inordinate burden of indigent care costs that have been traditionally assumed by St. Joseph Hospital and the University.

Several important changes have been made in the administration of the medical school. Dr. N. Kenneth Furlong has been appointed as Associate Dean for Continuing Medical Education, a new position. He also has appointments as professor of medicine and Associate Director for outreach programs at St. Joseph Hospital. Dr. Mathis Frick, head of the gastrointestinal section, department of radiology, at the University of Minnesota, will join the faculty June 1, as professor and chairman of radiology. He served his residency and a fellowship in nuclear medicine at Minnesota after obtaining his medical degree from the University of Berne, Switzerland, in 1974. Dr. Eugene Barone, who has been serving as acting chairman of family practice at Creighton, has accepted appointment as chairman. Dr. Barone is a 1976 graduate of the Creighton University School of Medicine.

Search committees are nearing the end of their selection processes for chairs in the departments of medicine and psychiatry.

Of 107 senior medical students who are graduating this spring, 50 of the 93 involved in the residency matching program obtained their first choice of postgraduate programs. Nineteen of our seniors are entering the specialty of medicine, 16 surgery and 12 pediatrics. Twenty-three will be serving their residencies in the Creighton University Affiliated Hospitals Graduate Training Programs and three are continuing their education at the University of Nebraska Medical Center.

Medical school tuition at Creighton has been set at $10,790 for the 1985-86 academic year, keeping the rate among the lowest for private medical schools throughout the country.

In a program instituted this year to acknowledge outstanding accomplishments, several awards were made to outstanding faculty members. Dr. John Daniel Egan, professor of medicine and chief of nephrology at the Veterans Administration Medical Center, was winner of the Distinguished Professor Award; Dr. Walter O'Donohue won the Distinguished Service Award; Dr. Emmet Kenney, the Master Clinician Award; Dr. William Schlueter, Dedicated Teacher Award; Dr. John Baumstark, Distinguished Research Career Award; Dr. Yuen-Sum Lau, Young Investigator Award; Dr. Joseph Lynch, Distinguished Continuing Medical Education Award.

Preparations are underway for the LCME accreditation site visit to the Creighton School of Medicine, scheduled for next October.

I extend my appreciation to the House of Delegates for providing me the opportunity to submit this report on Creighton University School of Medicine activities.

Respectfully submitted,
Richard L. O'Brien, M.D.
Dean

REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

During the past year, a major focus of the College of Medicine has been dealing with the numerous dimensions of change which surround us. We have attempted to discover the impact on the College of DRG's, HMO's, PRO's and changing Medicare regulations. Assessing the impact of competition is a rapidly changing health care delivery environment also has required major attention. Of equal significance has been the need to identify appropriate responses to the effects of manpower studies, animal welfare regulations, educational process studies and reduced federally supported student aid.

During this period major personnel changes also have occurred. Dean Alastair Connell left the College of Medicine October 1, 1984 to become the Vice President for Health Sciences at Virginia Commonwealth University in Richmond. A very aggressive search led to several desirable candidates for Dean and the selection of Robert Waldman, M.D. as Dean Designate. He will assume the Dean's position in July 1985. He is currently the Chairman of Medicine at the University of West Virginia.

Layton F. "Bing" Rikkers, M.D. has assumed the Chair in Surgery. We are pleased that Paul Hodgson, M.D. has agreed to remain on the faculty. A liver transplantation team, headed by Byers "Bud" Shaw, M.D., plans to initiate this new service in August 1985.

Efforts to improve efficiency and strengthen the organization at UNMC has led to the merger of the Departments of Surgery and Urology.

Harry McFadden,Jr., M.D. has indicated his desire to relinquish the Chair in the Department of Medical Microbiology, after 29 years of faithful productive leadership, effective July 1, 1985. Medical Microbiology will be merged with the Department of Pathology and Laboratory Medicine to form the new Department of Pathology and Microbiology at that time. Dr. McFadden has agreed to remain on the faculty.

Merrill T. Eaton, M.D. has indicated his desire to relinquish the Chairmanship of Psychiatry after providing 17 years of leadership and an active search is underway to identify his successor. Administrative reorganization will result in the Nebraska Psychiatric Institute becoming a unit of University Hospital and Clinic while the academic department will revert administratively to the College of Medicine.

William R. Ruegamer, Ph.D., after overseeing the initiation of the School of Allied Health Professions and providing dedicated leadership for 10½ years, has asked to be relieved of the position of Associate Dean. Reba Benschoter, Ph.D., Director of Biomedical Communications, has agreed to succeed Dr. Ruegamer.

An extensive project to study and implement computerization for ambulatory care management and record keeping is underway in the General Internal Medicine Clinic. It shows great promise and we are very enthusiastic about its potential contributions.

We continue our efforts to balance apparent manpower needs and obligations to provide access to medical education. We anticipate a class of approximately 120 freshman medical students this fall.

All of our spring graduates have obtained house officer positions for next year. Nearly 90% gained one of their top three choices in the match. The University house officer programs filled 49 of 51 positions offered.

The College of Medicine, NMA and NMA Medical Student Chapter jointly sponsored an introduciton to medical education for 15 members of the Legislature in January. This program was highly regarded by all those involved and may evolve into an annual event.

Your support of the College through the years has been greatly appreciated. As we enter the critical period ahead our continued communication and your faithful support are even more vital as we attempt to identify the needs of our society and respond to them.

Respectfully submitted,
Charles A. Dobry, M.D.
Interim Dean

REPORT OF THE NEBRASKA MEDICAL FOUNDATION, INC.

Howard A. Dinsdale, M.D., Lincoln - President; Stanley M. Truhlsen, M.D., Omaha; C. T. Frerichs, M.D., Beatrice; Roger Massie, M.D., Plainview; Wm. Chleborad, M.D., Fremont; Robt. Herpolsheimer, M.D., Staplehurst; Robert Quick, M.D., Crete; Thomas Wallace, M.D., Gordon; Warren Bosley, M.D., Grand Island; George J. Lytton, M.D., Hastings; R. E. Donaldson, M.D., North Platte; R. G. Heasty, M.D., Scottsbluff; Herbert E. Reese, M.D., Lincoln; Francis D. Donahue, M.D., Omaha; Dwaine J. Peetz, M.D., Neligh.

We wish to initiate our Annual Report to the NMA House of Delegates with an expression of appreciation and gratitude for the loyal support the Nebraska Medical Foundation has received from the physicians and the medical auxiliary. Contributions since our last report at the 1984 Annual Session is $8,805. Each of you are to be commended for these contributions that have permitted the Foundation to provide a long standing loan program, establish scholarships and provide financial support to the Tumor Registry project. All of these activities are demonstrations of medicine's commitment to medical education, research and improvement of public health. You can take just pride in these valuable programs which would not have been possible without your contributions. The officers and Board of Directors of the Nebraska Medical Foundation are deeply indebted to you for this loyal support.

The thrust of this report is to provide you with a resume of activity to demonstrate the importance your contributions play in Foundation activity.

Student Loan Program: This ongoing and valuable program has just completed 20 years of service to the medical students in our state. When the program was first initiated in 1948, the Foundation made limited loans to the students. As the demand for funds increased, the Foundation in 1964 approved an expanded program whereby student loans are underwritten by the Nebraska Medical Foundation. In the past 20 years, over one and three-quarter million dollars has been loaned to medical students. Under this program, students are eligible to borrow up to $2,500 per year from the Nebraska Medical Foundation. In turn, the Foundation underwrites the repayment of that loan, if default should occur, to the First National Bank & Trust Company of Lincoln who provides the funding. The agreement calls for the bank to loan twelve dollars and fifty cents for every dollar of reserve that the Foundation has on deposit. In addition, the Foundation must retain a reserve of not less than eight percent of all outstanding loans. In addition to this loan activity, the bank has on numerous occasions assisted the students by consolidating other loans into their student loan which has been most beneficial to these individuals needing such assistance. The bank also provides fiscal advice to the loanees on occasion as many students accumulate sizeable debts in completing medical training.

At the present time, the Nebraska Medical Foundation has loans amounting to $95,807 to students currently in school. In addition, we have an outstanding loan balance of $290,832 to students who have completed medical school and are currently in residency training or in medical practice. Under the loan program, the graduates are encouraged to begin repayment when they are in residency training. Payment is required to be initiated within five months after entering practice.

To date, the Foundation has been most successful in its loan repayment program. Our records indicate that just over $5,000 has been uncollectable since the expanded program began in 1964. At the time of this report, the loan program continues to meet the loan needs of the medical students.

Scholarships: In 1977, the Foundation expanded its activities to include scholarships in cancer and heart research projects of medical students. This program currently provides for a $2,000 scholarship in medical fields of research and is available to one student applicant from each of the two medical schools. Students whose projects are selected receive an initial $1,000 at the Annual Session and the final $1,000 upon receipt of the research paper. We continue to have a number of applicants each year and have been providing at least one scholarship per school on a yearly basis. These individuals are recognized by the House of Delegates at the Annual Session.

The Foundation plans to continue this activity and is hopeful that it can be expanded if funding is received through contributions.

Tumor Registry: The most recent activity of the Foundation has been the underwriting of expenses for development of the Nebraska Voluntary Tumor Registry. Through this funding the Tumor Registry has organized, and a standardized reporting program for all hospitals developed. A majority of all tumors identified in Nebraska are now reported to the Tumor Registry Program and it is hoped the goal of 100% will be reached in the not too distant future. In addition, certain hospitals in the State of Iowa who have Nebraska patients are also participants in this unique program.

Nebraska can be proud of the volunteer program and the quality of service it provides to the medical community and the citizens of our state. In addition to collection of statistical data, the program will also be available for research projects. The Foundation is pleased to have a role in this program and gives thanks and recognition to all those who have contributed so faithfully in the development and operation of this activity.

In conclusion, the Nebraska Medical Foundation is pleased to have a role in both medical education and research. Our success is directly related to the support of the medical community over the years and the dedication of those participating in its several programs. As we look toward the future, we see continuing needs for the philanthropic activity of the Nebraska Medical Foundation and ask that you keep the Nebraska Medical Foundation in mind when considering contributions. Support from the medical profession and their many friends in the community through gifts, wills or property will assure our continued success in meeting the challenges of tomorrow.

NEBRASKA FOUNDATION FOR MEDICAL CARE REPORT OF THE STEERING COMMITTEE

O. R. Hayes, M.D., Lincoln - Chairman; David Bacon, M.D., Kearney; John D. Coe, M.D., Omaha; Stuart Embury, M.D., Holdrege; Dale Michels, M.D., Lincoln; Donald Pavelka, M.D., Omaha; Dwaine J. Peetz, M.D., Neligh; Francis Donahue, M.D., Omaha; Richard Raymond, M.D., O'Neill; Henry Smith, M.D., Lincoln; Herbert E. Reese, M.D., Lincoln.

Following the fall of 1984 NMA House of Delegates Meeting, the Nebraska Foundation for Medical Care became operational on October 1, 1984 as the PRO Organization for Nebraska. By the start-up time, the full non-physician reviewer staff under the direction of Miss Nancy Balmer was completed and Dr. Jack Coe had accepted the challenge as the Medical Director.

The initial PRO activity revolved around the preadmission certification for the seven elective surgical procedures, the criteria of which was approved by the various Nebraska surgical subspecialties. Training sessions were conducted in Lincoln and Omaha for physician reviewers and plans for a similar program were considered for western Nebraska. Various members of the Steering Committee provide local or short informational programs to various medical staffs, societies, and on an individual basis. Additional programs for physicians, administrators and medical record or utilization review personnel will be provided by request as time and personnel availability will permit.

Soon after the start-up, the PRO found that it was responsible for any reviews not completed by the Fiscal Intermediaries. As a result, and without additional compensation, the PRO received no reviews from Mutual of Omaha and 5,540 reviews from Blue Cross-Blue Shield prior to 10/1/84! This backlog has taken a nearly full-time reviewer effort until March which resulted in some of the hospitals not receiving their initial review until some period following the close of the quarter on December 31, 1984. The review activity for all hospitals is now in full swing and any problems are being solved promptly and usually with positive results between the PRO and the reviewed hospitals.

Not all physician reviews have been smooth, however! There have been concerns on the part of physicians who have had claims denied that their practice was faulty. These feelings seem to arouse anger in the affected physician and has developed an antagonism toward the program. Some of this antagonism has been directed at the reviewing physician as a personal affront. However, many of these denials have been reversed during a reconsideration hearing by **three** additional physicians when **additional** information was provided by the attending physician! Therefore, it is the feeling of the Steering Committee, that if an attending physician would have provided the same information initially in the chart, the case would **not** have been denied in the first review! **Documentation** of the events surrounding the hospitalization, the plan of therapy, and the plan of dismissal is the **key** to an adequate medical record that can meet established criteria. With this complete documentation, the Review Coordinator can find adequate reason for hospitalization and can approve the claim. Also should the Review Coordinator find that the criteria are not met, the physician reviewer may be able to approve the claim based on **adequate** documentation and progress notes. **Remember that the NMA established the NFMC** in order that **physicians** would make medical decisions and thus be advocates of good medical care for the Medicare recipients.

Dr. Dave Bacon, Chairman of the Quality Assurance-Utilization Review Committee, has had ongoing efforts with a representative of each Medical Specialty organization in providing additional or revised criteria for the various DRG groups. **Any** Nebraska physician may contact Dr. Bacon or the PRO if he or she feels that the criteria for any situation should be broadened, tightened, or modified in any way. Each member of the NFMC should feel free to make suggestions to the PRO at any time and their concerns will be addressed and incorporated if found to be useful.

During early March 1985, a PRO Review Team from the HCFA Regional Office in Kansas City, made a site inspection to NFMC. At that time, the review team reviewed the PRO activities at the Clarkson, Bryan, Papillion, and Crete Hospitals. Aside from some administrative changes, the NFMC was congratulated on their accomplishment at that time and the excellence of the Staff activities.

The NFMC members should know that in addition to the efforts locally by staff and the physician members, a large chunk of credit is to be extended to the Staff from the Kansas Foundation. Their unswerving willingness to guide the NFMC has resulted in a top-notch program that will succeed in difficult times for the patients and physicians of Nebraska.

There is a continued interest by the NFMC to enter into contracts for **Private Review** with business groups in Nebraska. At this time, a small contract with Tenneco Corporation is in effect. A proposed contract has been forwarded to the Nebraska Department of Social Services for providing Medicaid Review. No comment has been received from this agency to this date.

At the Board of Directors Meeting on April 26, 1985, there will be some revisions in the composition of the Board, changes in By-Laws, and additional business as indicated. If possible, a verbal report will be given to the Reference Committee on other actions taken.

Finally, an appeal is made to all Nebraska physicians to become involved in the PRO activities and to try **not** to take the actions personally when denials are issued! Each of us has to try to understand the program, meet the stipulations, and continue to provide the superior medical care to all patients that Nebraska physicians have been doing for so long.

Included for informational purposes are statistics relating to NFMC activity through March 31, 1985.

10,000 Reviews conducted
340 Admission denial
261 DRG revisions
2 Procedure denials
3 Preadmission denials
144 Requests for reconsideration
50 Decisions reversed
31 Upheld
65 Reconsiderations to be conducted
85 Hospitals started 1st quarter with favorable waiver
28 of the 85 hospitals lost waiver 2nd quarter
57 of the 85 retained favorable waiver 2nd quarter
10 Hospitals without waiver 1st quarter regained
4 Hospitals have not had favorable waiver either quarter

REPORT OF THE STATE DEPARTMENT OF HEALTH

Just one year ago, the Health Department reorganized our program divisions into five bureaus. I would like to very briefly describe these bureaus, and mention a few issues pertinent to each. The directors of these bureaus, along with my two deputy directors and my legal counsel form a management team for the department. I have been very pleased with the enthusiasm and leadership within this management team, and would like to encourage you to contact any of these people if you have questions, problems, or suggestions about the activities of the Health Department.

I. Bureau of Examining Boards:
Director — Laura Partsch, 471-2115

The Bureau of Examining Boards continues as before with the responsibility for licensing and certification for over 50 professional groups through 19 individual professional boards. (This bureau licenses approximately one in every 20 Nebraskans.) We recognize the need for efficient and accountable follow-up on complaints against individual licensees, and have taken several steps to accomplish this. We have added a full time attorney for the Bureau, and have requested three additional staff to provide support to the boards. Lee Lucke now provides full time direction to our investigation area, resulting in additional personnel available in that area, and we are actively evaluating our need for additional staff. Recently, the Board of Examiners in Medicine and Surgery passed a resolution supporting the addition of additional investigative staff for this bureau. In addition to this, we have requested and received additional support from the Attorney General's office, and will be discussing a memorandum of understanding with the AG's office which will define what will be expected of both the AG's office and the department in order to assure prompt and fair action on license questions.

II. Bureau of Health Planning and Data Management:
Director — John Sahs, 471-2337

This bureau brings together our Divisions of Vital Statistics, Health Data and Statistical Research, Health Planning, and Developmental Disabilities Planning. A major challenge for this bureau over the coming year will be the implementation of the provisions of LB407. With the strong support of the NMA, this bill will bring some structure to the many questions and controversies involving licensure and certification of various groups. With advice from the Board of Health, the Health Department will be appointing technical committees to study the approximately ten separate requests for new or altered licensure or other forms of credentialing. Reports from these technical committees, from the Department of Health, and eventually from the Board of Health should provide guidance to the legislature in considering who should be credentialed, and should bring to the front the health considerations involved in such questions.

III. Bureau of Health Protection:
Director — Burke Casari, 471-3979

This bureau brings together our divisions which regulate individuals, including the licensing of hospitals and nursing homes, the certificate of need support staff, radiological health, and environmental health functions. We are attempting to increase the department's ability to monitor and respond to the increasing range of real and perceived environmental health threats. Through a three year capacity building grant from the Centers for Disease Control, we have hired a toxicologist, Dr. Candace Jacobs, and will be increasing our efforts to monitor and eventually prevent exposures to pesticides and other toxic farm-related chemicals. We have continuing concerns about the threats to our drinking water supplies. Nitrates provide the most visible evidence of this threat but it is also evidenced by volatile organic compounds and natural radioactivity in some Nebraska water supplies. There has never been a greater need for a very complete and accessible cancer registry in Nebraska, and we continue to hope that the current voluntary effort will provide this.

IV. Bureau of Medical Services and Grants:
Director — Douglas Campbell, 471-3980

This bureau brings together our programs that pay for medical care or provide grants to others to provide health or nutritional services. It includes the Emergency Medical Services, Nutrition including the W.I.C. program, Maternal and Child Health, and a number of special health programs including the Genetics program, the Diabetes program, Developmental Disabilities Grants, and the Cancer Research Program. This year we have changed our method of awarding the money available in from the Prevention Block Grant and the Maternal and Child Health Block Grant. We had 110 concept papers submitted in response to a request for proposal in these areas, and will plan to ask for an increased level of accountability from all block grant recipients and continue to develop ways to insure that these funds are effectively applied in the areas of greatest need.

V. Bureau of Community Health Services:
Director — Franklin Harris, 471-2101

This bureau includes the Division of Disease Control, the Division of Community Health Nursing, Dental Health, and Health Promotion and Education. I would like to call your attention to the planning we have done in response to the growing epidemic of Acquired Immunodeficiency Syndrome or AIDS. Although Nebraska has been spared with only a small number of cases to date, the dramatic increase in this disease nationally makes it clear that we cannot ignore it here in Nebraska. In addition, because blood banks will be screening for evidence of exposure to HTLV-III, the AIDS virus, we will all have to be prepared to give effective advice to those who may have a positive (or false positive) result in this system. The Health Department has received a grant from the CDC to provide resources in this area and this effort will be directed by Dr. Paul Stoesz, the state epidemiologist.

Also in this bureau, I would like to call attention to the Governor's Health Promotion Coordinating Council. Dr. Eileen Vautravers from your health education committee serves on this council. The council has drafted the beginnings of a state health promotion plan, and there will be an important role for your health education committee as well as every practicing physician in this effort. I think that it is vital that physicians maintain a leadership in our health promotion efforts in Nebraska.

This bureau will also be administering a new FDA grant to improve the reporting of problems with medical devices to the FDA database, and to improve the access of Nebraska physicians and hospitals to the information about these problems throughout the country. This effort should be the first in a number of efforts to increase the electronic communication between physicians, hospitals, and the State Health Department. As computer technology becomes more available, it is important that we consider ways to tie these groups together.

Respectfully submitted,
Gregg F. Wright, M.D.
Director

REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

Joel T. Johnson, M.D., Kearney - Chairman; R. A. Blatny, M.D., Fairbury; Paul E. Collicott, M.D., Lincoln; John D. Coe, M.D., Omaha; Jon J. Hinrichs, M.D., Lincoln; Arnold Lempka, M.D., Omaha; Joseph Stitcher, M.D., Lincoln; R. C. Weldon, M.D., Nebraska City; Don Graham, Omaha.

THIRD A.M.A. DELEGATE

The Nebraska Medical Association has over 75 percent of its membership which also belongs to the American Medical Association and is therefore granted an additional delegate. When the Nebraska Medical Association qualifies for this delegate, it is recommended by the Commission on Association Affairs that the Board of Directors would select one of the AMA alternates to serve as the additional delegate, and the Board would designate the President as an alternate and the President-Elect or the Secretary-Treasurer to serve as the additional alternate. It was felt by the Commission that this would lend continuity, but at the same time, save substantial funds because of the fact that the President and the President-Elect would already be attending the AMA meetings.

Proposed amendments to the By-Laws are listed below:

Amendment to Chapter VII, Section 1(1)

Except as hereafter provided, delegates to the American Medical Association, and their alternates, for terms of two years each but not to exceed five consecutive two-year terms after May, 1978; provided, however, for good cause shown, the House of Delegates may elect to retain an AMA Delegate or Alternate on a year-to-year basis. **If at any time Nebraska is permitted by the AMA to have one additional delegate and one additional alternate based upon Nebraska's fulfillment of criteria relating to percentage membership in the AMA, the Board of Directors shall select one of the AMA alternates to serve as the additional delegate and the Board of Directors shall designate the President as an AMA Alternate and shall select either the President Elect or the Secretary-Treasurer to serve as the additional alternate.**

Amendement to Chapter VIII, Section 6

Members of the Board of Directors may not hold two elected positions at the same time; **provided, however, this shall not prohibit the President-Elect or Secretary-Treasurer to serve as the additional alternate to the American Medical Association as provided in Chapter VII, Section 1(1).**

Amendment to Chapter IX, Section 1

(11) Serve as the AMA Alternate to the American Medical Association, if so designated, as described in Chapter VII, Section 1(1).
(Renumber current subsection (11)

Amendment to Chapter IX, Section 7

(9) Serve as the additional alternate to the American Medical Association, if so designated, as described in Chapter VII, Section 1(1).

Amendment to Chapter IX, Section 2

(9) Serve as the additional alternate to the American Medical Association, if so described in Chapter VII, Section 1(1).

Amendment to Chapter X, Section 1(14)

(14) Fill vacancies occurring in any offices and in Delegates to the American Medical Association and their alternates, subject to the approval of the House of Delegates at its next regular session except if filled pursuant to Chapter VII, Section 1(1).

LIFE MEMBERSHIP BENEFITS

The criteria for Life Membership should be reviewed. It now costs the NMA in excess of $3,600 per year just to supply the Nebraska Medical Journal for Life Members. It is the recommendation of the Commission that Life Members be charged a minimal fee for the Journal with the option of not taking it. This proposal is submitted to the House of Delegates for consideraton. Appropriate By-Law revisions could be considered at the Fall Session.

ASSOCIATE MEMBER CATEGORY IN THE NMA

It is felt that persons who retire from medicine and do not pursue another medically related career, and do not receive any compensation relative to their M.D. degree, and do not meet the criteria for Life Membership status, would be eligible for an associate status if they retire after 25 years. The associate member would pay for the services from the NMA such as the Journal mailings, etc. This recommendation is submitted for consideration by the House of Delegates. Here again, appropriate Article and By-Law changes would need to be considered at a future session of the House of Delegates.

MEMBERSHIP BENEFITS

The Commission is doing an indepth study of various benefits that NMA membership could provide. Membership benefits could not only be of benefit to the physician members themselves and therefore offset a part of the cost of the NMA dues, but there is the potential for the NMA to receive a commission from any broker of the various services provided by the NMA packages. An example of this would be to follow the Washington State Medical Association in that magazines for the physician's offices and their homes are offered through the Medical Society and therefore could save the members the money directly, and also the extra revenue to the Association could defray expenses of the Association.

There are many other types of benefits to the NMA members and to the Association itself that are being considered. Many types of insurance, retirement plans, etc. are a consideraton. Assistance to medical students could be rendered early through the student medical association regarding various types of insurance, the setting up of practices, practice opportunities, etc., all of which would increase the likelihood of the students joining the student NMA and then transferring their membership and becoming active in the NMA upon their graduation. It is felt that as alternative health care delivery systems appear on the scene that students and young physicians may feel that the NMA membership would not be worthwhile for them and that the development of plans and benefits would enhance the likelihood of these people becoming active in NMA affairs.

Other benefits, some of which are now in existence, are a collection system, generic contract analysis by legal counsel, group purchasing, a computer system to link all NMA members (this possibility is being studied by Dr. Stuart Embury), "Gold Card" or "Premium Card" for members, such as the AMA, Visa Card. Additional possibilities for membership benefits are reciprocal membership through the Association in private clubs. It is felt that the Commission and the Association should pursue the subject of marketing of physicians.

The lease back of office personnel concept was discussed, but since this is somewhat controversial, it is felt that the NMA should not pursue this issue as a group at this time.

Dr. W. C. Weldon was asked to work with the NMA office relating to insurance packages. Drs. Johnson, Blatny and Stitcher will continue to pursue the information and possible development of the benefits packages and practice related benefits.

The Commission on Association Affairs solicits comment from the membership regarding benefits and benefit packages.

REPORT OF THE COMMISSION ON HOSPITAL MEDICAL STAFF

Steven Schwid, M.D., Omaha - Chairman; Harry Keig, M.D., Papillion; Barney Rees, M.D., Omaha; Glen Lau, M.D., Lincoln; Joseph Rogers, M.D., Lincoln; Richard Toren, M.D., Lincoln; Richard Hranac, M.D., Kearney; Gerald Rounsborg, M.D., North Platte.

The Commission has held a telephone conference and two meetings since its origination by the House of Delegates. The majority of our time has been expended through review of voluminous material available on this subject and addressing the charge and responsibilities given to the Commission. As part of this responsibility, the Commission has taken several actions.

A program on addressing the area of liability of credentialing has been recommended for endorsement by the NMA. The program would be in response to the JCAH which has asked hospitals to specify exact privileges physicians in each department should have. It is the feeling of the Commission that information on this vital subject is not readily available to physicians and hospitals in Nebraska. The Commission intends to seek the participation of the Nebraska Hospital Association in such a program and a date of September 5, 1985, has been set for this seminar. Information will be provided to the membership concerning this program as additional details are considered and arrangements are finalized.

In addition, it is the intent of the Commission to visit with individual physicians and hospital medical staffs regarding joint venturing and a succeeding meeting of this group will be oriented toward this educational process. The Commission cordially invites any individual physicians or representatives to medical staffs to contact them via the NMA Headquarters Office if they are interested in meeting with the Commission to discuss specific issues. Through this educational process, the Commission is hopeful it can be of assistance to the physicians of the state as the issues and subjects continue to manifest themselves.

Another issue on the agenda of the Commission is visitation with hospital representatives regarding networking activity. The Commission is not limiting itself to just the above issue but will express interest and review any and all aspects relating to the hospital medical staff relationship concept. We look forward with anticipation of providing the membership with meaningful reports and recommendations in this everchanging area of health care delivery. The Commission welcomes any input or recommendations the House may have with regard to the activities and subject matter assigned.

As Chairman of the Commission, I will be attending the AMA Meeting of the Section on Hospital Medical Staffs in Chicago in June. This will be the first opportunity for the NMA to have official representation at this national meeting.

REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

Craig Urbauer, M.D., Lincoln - Chairman; Charles S. Wilson, M.D., Lincoln - Vice-Chairman; Dwaine J. Peetz, M.D., Neligh - Advisor and Counselor; Michael Breiner, M.D., Lincoln; Judith Butler, M.D., Superior; James H. Dunlap, M.D., Norfolk; Vernon F. Garwood, M.D., Lincoln; Charles Gregorius, M.D., Lincoln; Ronald Klutman, M.D., Columbus; Max W. Linder, M.D., Lincoln; John T. McGreer, III, M.D., Lincoln; Bruce Miller, M.D., Lincoln; Robert Osborne, M.D., Lincoln; Richard Raymond, M.D., O'Neill; Blaine Y. Roffman, M.D., Omaha; F. F. Paustian, M.D., Omaha; Mylan VanNewkirk, M.D., Scottsbluff; Dennis G. O"Leary, M.D., Omaha; Barbara Heywood, M.D., Papillion; Jerald R. Schenken, M.D., Omaha; Mr. Terry A. Davis, Omaha; Mr. Christopher G. Olson, Omaha.

The Commission on Legislation and Legal Affairs has been meeting regularly and frequently and commission meetings have been well attended. We had preliminary organizational and planning meetings in the Fall of 1984, in preparation for the beginning of the long legislative session of the Unicameral which is still in session. Arrangements were made for a Legislator Information and Awareness Day which was held at the University of Nebraska College of Medicine on January 14, 1985 and 15 legislators and their spouses attended along with several members of the Nebraska Medical Association, faculty, students and administration of the College of Medicine. It was felt by the NMA that this was a very worthwhile endeavor in providing some insight to the Senators about various aspects of medical education and about the complexity of operating the College of Medicine. It was anticipated that this event could be continued in future years, particularly for newly elected Senators.

Physicians of the NMA also hosted 32 Senators and spouses at a social evening at the Lincoln Country Club on April 10, 1985. This was oriented more towards an evening of sociability and making acquaintances, with the major thrust being an attempt to have physicians from each Senator's home district host their Senator to a meal in congenial surroundings and perhaps assist in making it easier to pursue subsequent contacts with the Senators.

The Commission has monitored perhaps the largest group of bills relative to the medical profession and the practice of medicine to be presented in any single session in recent memory. Many of these bills related to licensure or change in scope of practice of different groups and most of these bills were dealt with by attempting to have them fall under the provisions of LB 407. LB 407 was introduced by Senator Don Wesely and the Public Health Committee, with considerable input from medicine, and in essence funnels all requests for licensure, certification, registration, or scope of practice through the State Health Department before presentation to the Unicameral for final decision. At this date, LB 407 is on Final Reading and at this time indications for its passage and ultimate signature are quite favorable.

A listing of bills of interest and their current status is listed below.

LB 61 — Authorize public hospitals to participate in cooperative ventures. Final Reading.
LB 130 — Include pituitary gland in Anatomical Gift Act. Select File.
LB 132 — Modify supervision of Physician Assistant. Select File.
LB 157 — Prejudgement interest. General File.
LB 186 — Sales tax on services. Killed.
LB 320 — Adult Protective Services Act. Committee.
LB 361 — Sudden Infant Death autopsies. Committee.
LB 382 — Uniform Billing and Data Collection Act. General File.
LB 410 — Living wills. Killed.
LB 496 — Seat belts. Select File.
LB 524 — Motorcycle helmets. Committee.
LB 565 — Patient care information act. Committee.
LB 676 — Direct reimbursement of nurse anesthestist. Committee.
LB 707 — Delete M.D. requirement as Director of Health. Killed.

As usual, there has been considerable amount of time and effort expended by the staff of the NMA, with very thorough and capable support by our legislative lobbyist. These gentlemen have provided continual NMA presence in the halls of the Unicameral, provided expert guidance and counseling for the organization and their work is to be commended. Also the officers of the Association, in particular Dr. Reese and the members of the Board of Directors has spent considerable time and effort in pursuing the legislative objectives of the NMA and they deserve the thanks of the organization. Many individual physicians representing the entire State of Nebraska from Scottsbluff to Omaha have also contributed much time, effort, and money in this regard, and the NMA Auxiliary under the leadership of Mrs. Krause, Mrs. Kruger, Mrs. Forker and Mrs. Osborne has been especially helpful.

It is ever more apparent that the political process will impact the lives and practices of each individual physician and it is therefore incumbent upon each individual physician to be aware of what is going on and to participate more directly and actively in the political process in order to maintain those principles and objectives which are felt to be important to both individual practice and organized medicine. In this latter regard it cannot be over-emphasized that it is important for us to attempt to have as strong a voice as possible in national affairs as well as local affairs and in this regard support of the American Medical Association should be encouraged.

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

Rodney Basler, M.D., Lincoln - Chairman; Herbert D. Feidler, M.D., Norfolk; Edward E. Gatz, M.D., Omaha; Donald T. Glow, M.D., Omaha; John J. Hoesing, M.D., Omaha; Roger P. Massie, M.D., Plainview; Donald E. Matthews, M.D., Lincoln; C. Lee Retelsdorf, M.D., Omaha; Harlan C. Shriner, M.D., Lincoln; F. Thomas Waring, M.D., Fremont; Mr. Timothy Loker, Omaha.

Promoting the Physician as Patient Advocate

The operating premise for the Commission on Public Affairs of the Nebraska Medical Association is that "the physicians of this state are continuing to do their jobs well, and the people need to be told about it". During this period which NMA President, Dr. Herb Reese, has so appropriately labeled "Medicine in Transition", patients are more eagerly looking for a health care advocate than ever before. Only the physician has the combination of training, experience, information and compassion to serve in that role.

The Commission is acting on this premise in two separate directions. First, we are evaluating the attitudes and opinions of the NMA membership, as disclosed by responses to the Association's recent professionally-administered internal poll. The Commission is trying to determine those positive attributes of which we, as members, wish to make the public especially aware. Second, we are attempting to present these positive accomplishments to the general public in such a way as to stimulate their support.

Current activities of the Commission aimed at improviding public relations through gratuitous public service include the preparation and distribution on a regular monthly basis of "Health Tips" and other news releases which describe new medical findings in terms easily understood by laymen. These short subjects are released to local newspapers and radio stations across the state.

Newspapers receive copies of the NMA President's annual "State of the Health" report which is produced for media representatives. Radio stations also have made available to them recorded "spots" on health items by the NMA President which they often use. In addition, the Commission helped coordinate member participation in the televised "Health Line" series, and secure appropriate spokespersons for conferences and media interviews.

New programs which have already been undertaken by the Commission in the direction of internal relations include Nebraska Medical Journal articles, informing of NMA commission, committee and task force activities. An educational program aimed at members of the medical community who have not yet joined the NMA is progressing from the planning stage.

A number of new projects have been initiated which are intended to advance the concept of the physician as patient advocate among the general public. Included in these is the promotion of fitness, good health habits, and the attitude of wellness through news releases and eventually a video tape file. Better exposure to the press of selected Nebraska Medical Journal articles, including interviews with the authors, is expected to both increase lay interest and awareness and stimulate more state physicians to become contributors. Formal and informal coalitions with leaders of business and labor are being explored. Also in the planning stage is a booklet explaining to patients the various forms of health insurance and distribution systems, with the advantages and disadvantages of each.

And finally, a means of formally presenting a catalogue of organized medicine's many accomplishments is being considered. One possibility is the production of a descriptive pamphlet for office waiting room distribution, discussion items such as NMF student loans and scholarships, CME accreditation, tumor registries, peer review, and the Health Gallery with the mobile van in which we can justifiably take pride.

REPORT OF THE TASK FORCE ON INTER-RELATIONSHIPS AND INTERPROFESSIONAL COOPERATION

Robert F. Shapiro, M.D., Lincoln - Chairman; Charles L. Barton, M.D., Lincoln; R. A. Blatny, M.D., Fairbury; Kevin Case, M.D., Omaha; John D. Coe, M.D., Omaha; Charles G. Erickson, M.D., Lincoln; Joseph M. Holthaus, M.D., Omaha; Mr. Michael Phillips, Omaha.

Ethics-Intraprofessional Relationships in Professional Solidarity in Todays Competitive Climate

In the turmoil of today's competitive health care environment, the emphasis, not of the profession's choosing, has been changed from quality and access to lowest cost for services rendered.

To cope with this changing environment and to retain the best characteristics and ideals of our profession, the Nebraska Medical Association formed a long range planning committee and appointed several task forces to deal with specific assignments.

The primary concern of the Nebraska Medical Association was that a competitive environment which pitted practitioners against each other locally, would hinder, impede or even destroy their ability to work together to cope with problems of mutual concern and consequence.

One task force explored the possibility of a state-wide IPA or PPO and concluded, based on their research and legal advice, that such was not feasible because of lack of integration or practices of professionals, who would ordinarily be considered competitors. This opinion is not universally shared and at this time, some efforts to accomplish the goal on less than a state-wide basis, are being made.

A second task force is putting together information on all of the different modes of alternative health care delivery. This information will be made available to physicians interested in these different structures so that they can make an informed choice based on unbiased information.

Our task force dealt with the complicated, rapidly-changing area of intraprofessional relationships and ethics. "How were practitioners to work together and compete against each other and wear both of these hats well?" Had not Ralph Waldo Emerson said "In failing circumstances, no man can be relied on to keep his integrity." Could such be true of physicians? Would our behavior sink to the lowest common denominator?

Ambivalence reigned in the task force — at times optimism and at times, pessimism held sway. The bottom line consideration was that the doctors are intelligent and relatively adaptable people, even if at time reluctant or even recalcitrant. We would be able to cope with this present phase of what may turn out to be a cycle.

Doctors will learn appropriate and ethical ways to compete and ways not to compete. These new ethical approaches will be developed. We will learn to market by looking at patient needs and meet those needs in a positive way. We will build and not tear down, or take away. Proper competition could maintain and even enhance quality.

We are not "pollyanna's" for such things as rationing were considered. The political tides will likely shift as people perceive that not only fat and fluff, but meat, sinew and bone i.e. basic medical services, are being effected by the changes.

Lest we become so focused on our own concerns that we ignore future doctors, we include some concerns of the students and residents who also worry about the future of the health care system:

1. Will there be a place for me to practice my profession at all, or in this state?

2. With debts that I have accumulated, will I be able to start up a practice?

3. Where will I learn to choose amongst the alternative health care delivery systems?

4. Where are the needs for the specialty I want?

5. Will there be any restrictions as far as hospital privileges are concerned?

6. What will happen with the malpractice situation?

And those are only a sampling of their concerns.

In the last analysis, the common thread or "commonality" as our President Dr. Reese, has referred to is the welfare of the individual patient, which is the real bottom line for all of this when we think about why we became doctors in the first place. Whatever the system, we need to be the individual patient's advocate. The lawyer is the advocate for even the most heinous of criminals. We should do no less for our patient. We should not abandon that patient to the perspective of a cohort population of one hundred thousand people. Let others look the patient in the eye and say "no", not us.

The problems identified and questions raised become the future agendas for the Nebraska Medical Association commissions and committees. They are the action plan for the 1980. Filing of the report to gather cobwebs is not our intent.

REPORT OF THE COMMITTEE ON HEALTH PLANNING

C. J. Cornelius, Jr., M.D., Sidney - Chairman; Gordon Adams, M.D., Norfolk; Lewiston W. Birkmann, M.D., Lincoln; James Carson, M.D., McCook; Chris Caudill, M.D., Lincoln; Allen Dvorak, M.D., Omaha; Dale Ebers, M.D., Lincoln; Louis J. Gogela, Jr., M.D., Beatrice; Roger Jacobs, M.D., Seward; Duane Krause, M.D., Fremont; Roger D. Mason, M.D., Omaha; John Porterfield, M.D., Lincoln; Donald Prince, M.D., Minden; C. Lee Retelsdorf, M.D., Omaha; Eugene Sucha, M.D., West Point; Thomas Wallace, M.D., Gordon; Teresa Olsen, Omaha.

The Committee on Health Planning has not had a formal meeting since the fall meeting of the House of Delegates but has continued to monitor health planning activities on the state and national scene and members of the Committee have served on special Task Forces of the Association during the interim.

Health planning activities have been rather slow this past few months but promise to increase in the near future. The 4th Edition of the State Health Plan is under development and should be ready for public hearing before the end of the year. Your Chairman continues to chair the Plan Development Committee of the Statewide Health Coordinating Council but is ineligible for reappointment to the SHCC when his term expires later this year. Drs. Bosley and Mason will continue to represent the NMA on this committee through the completion of the approval process for this 4th Edition.

The first set of policy recommendations of the AMA's Health Policy Agenda for the American People was reviewed by the Advisory Committee in February. These, plus additional policy statements will be reviewed by the Committee on Health Planning when they become available. This HPA process has been a most deliberate one to date and the benefits accruing to the medical profession and the AMA Federation remain to be seen. Included in this process are representatives of business, labor, the insurance industry, nursing, dentistry, allied health professions, government, etc. It is hoped that the involvement of these various segments of the economy will add credibility, understanding, and cooperation in the approach to health care in the future. Your Chairman has represented the NMA on the Advisory Committee. A copy of the HPA structure taken from Volume 2 of the Phase I Report is appended.

Your Committee on Health Planning looks forward to a busy year upcoming.

THE HEALTH POLICY AGENDA PROJECT

PURPOSE

The decade of the 1980s is a critical turning point in almost every facet of the nation's health care. Dramatic discoveries in biomedical science and technology are changing health care practices and procedures. New technologies such as organ transplants, genetics, dialysis, and other life-saving treatments, non-existent 10 to 20 years ago, have become part of accepted medical practice. Often these new technologies are accepted before the full financial and social consequences are clearly understood. As a result, they are raising serious cost-benefit questions and ethical issues about not only the quantity of services, but also the quality of the services and access to those services. It is expected that these dramatic scientific discoveries will continue on into the next decade.

Efforts to control costs and stimulate competition are also causing critical changes in health care delivery, financing, health manpower, and education. A bewildering array of public and private schemes for delivering and financing care are being implemented rapidly. And, the move toward competitive corporate health care has begun to alter traditional health care roles and relationships. Within this turbulent environment, laws are often passed and regulations written to allocate funds in one direction, while market forces have directed funds another way.

Changing demographic characteristics, particularly the changing age distribution, is another basic force affecting the health care environment. The percent of the population over 65 years old will increase by 27 percent by the end of the century. As a result, some predict that there will be more chronic health conditions, an increase in the number of days spent in the hospital, and an increase in the number of nursing homes and home health care and hospice programs.

Recent surveys indicate that the public believes fundamental changes may be needed in the health care system. Most Americans believe that the health care they receive is good, that they have adequate access to health care, but that the costs are too high. Public opinion polls indicate that many people involved in the delivery and financing of health care agree that fundamental changes are needed. Many physicians and physician leaders agree that costs are a serious problem, but believe that solutions should be pursued by building on the current system rather than by replacing it. Many observers fear that the changes being proposed and implemented will, to some degree, reduce the accessibility and quality of care available to the public and that Americans will be paying more out-of-pocket for their health care.

Frequently, during a time of tension, events take control and short-term and piecemeal decisions are made by both the public and private sectors. The result is usually a hodgepodge of inconsistent laws and policies. During these times, it helps to re-examine the basic values upon which health and the health care system are based and then develop a long-range comprehensive and cohesive social policy to guide government, the health professions, and the public through these complex health care issues. Clear statements are needed of this country's goals and priorities in health care.

To that end, a project called a Health Policy Agenda for the American People (HPA) was initiated to examine long-term health care issues and then provide workable advice and direction toward national health care policies. The HPA ws initiated by the American Medical Association in 1982 with the support of many other health, health related, business and consumer groups. Since its inception, the people and organizations involved in the project have demonstrated commitment to the challenging work of formulating collaborative solutions to pressing problems.

THE HPA PROCESS

The Health Policy Agenda project operates on one major premise — that a structured, consensus-building approach among knowledgeable people will yield reasonable, workable results. A two-phase approach was developed to guide HPA participants through this agenda-building process.

Phase I

During Phase I, 159 principles were drafted, reviewed, and approved. The principles are broad value statements of what should exist in a policy arena. They are statements of the most desirable circumstances or situations and should help guide individuals and organizations as they make decisions. The principles constitute a long-term foundation of the HPA project and form the basis for the evaluation of the policy proposals to be developed in Phase II. While some of the principles may be revised during Phase II of the project, it is not expected that they will change dramatically.

The principles include statements about equity, fairness, individual rights and responsibilities, professional rights and responsibilities, the role of the state, and the quality of health care and its cost.

A set of policy issues was also developed during Phase I of the project. Issues are situations or circumstances which need to be addressed and are ready for action or decision. An issue may be considered a problem or an opportunity. The 40 issues being addressed in the HPA project have "staying power" not only because they have economic origins, but also because they are intertwined with moral and ethical questions.

Phase II

During Phase II, HPA participants are addressing the issues by developing policy proposals which are responsive to the issues and consistent with the principles. When the project is completed, there will be 30-40 specific policy proposals which will be an agenda for collaborative action. The goals and priorities for maintaining and improving the American health care system will be clearly delineated and a course of action for achieving those goals will be outlined.

THE HPA STRUCTURE

The structure of the HPA encourages broad involvement, thorough review, and responsible decision-making. The component groups of the project are:
The Steering Committee
The Advisory Committee
Six Work Groups

The HPA is guided by a 32-member **Steering Committee** representing physicians, nurses, dentists, hospital administrators, insurance providers, the pharmaceutical industry, state and federal government, business and consumers. There are also three at large members of the Steering Committee. A list of the organizations involved with the project is in the final section of this report.

The primary work of the HPA is done by six **Work Groups**, consisting of representatives appointed from health, health related, business, and consumer organizations. Work Group members drafted the principles and are developing policy proposals that apply to the six areas of:

—medical science;
—health professions education;
—health resources;
—delivery mechanisms and processes;
—evaluation, assessment, and control;
—and payment for service.

In designing the HPA process, the Steering Committee also established an **Advisory Committee** to review and comment upon the Work Groups' draft principles, issues, and policies. Since an important objective of the HPA project is to involve many organizations with interests in health affairs, the 155-member Advisory Committee provides a wide spectrum of views while keeping the process workable.

At set intervals during each phase of the project, the Advisory Committee reviews and comments on the materials developed by the Work Groups. At the Advisory Committee meetings, the Committee interacts with the six Work Groups by suggesting revisions, deletions, and additions. Following this meeting, the Work Groups revise their material and present it to the Steering Committee. Final approval of the principles and policies rests with the Steering Committee which then releases them to the participating organizations.

At the beginning of the project, the Steering Committee identified the policy areas to be studied, established the methodology, and charged the six Work Groups with their tasks. The process which was used to develop the principles and the issues and which is presently being used to develop policy is outlined as follows:

—Each Work Group meets approximately four or five times a year to prepare draft materials to be reviewed by the Advisory Committee.

—Following the Advisory Committee meeting, the Work Groups revise their material and then forward their drafts to the Steering Committee.

—The Steering Committee reviews the Work Groups' drafts and the Advisory Committee comments, revises the Work Group reports, and approves the final version.

—After the Steering Committee approves the Work Groups' reports, the final product is sent to the various participating organizations. This process is diagrammed below:

Work Group → Advisory Committee → Work Groups →
Steering Committee → Participating Organizations

When the Steering Committee has developed the final Health Policy Agenda, it will be disseminated to the participating organizations. It is hoped that these policy proposals will form a common basis upon which the various participants can work together to influence the shape of health care policy in this country. The final approval of each organization's health care policy rests with that organization.

STATUS OF THE HPA PROJECT

This report marks the end of Phase I of the HPA project. The principles and issues presented here are the results of the collaborative efforts of over 350 individuals from 150 health-related, business, and consumer organizations who have been meeting since January, 1983.

The principles contained in this document are consensus statements reached after considerable deliberation by many participants from diverse organizations. Although seemingly general statements that are difficult to dispute, principles are powerful tools that participating organizations can use to formulate their own public policies, debate issues, testify before state and federal governments, draft model legislation, and organize educational efforts. Participating organizations can also use the set of principles as an effective internal educational tool to educate the staff and membership to their public policies. Organizations may decide to adopt those principles which are consistent with their own goals and purposes, change those policies which are inconsistent with these principles, and adopt the principles where no policy presently exists.

The issues really set the agenda for policy development. During the next year, all involved in the HPA project will be struggling to formulate solutions to these issues. Among the issues recognized by participants in the HPA as critical to the future of health care in this country are: funding for biomedical research; evaluation of health care technology and the role cost will play in availability of technology; enrollment of minorities in health professions education; educating caring and competent practitioners; financing health professions education; access to care; promoting quality care in a cost containment environment; the manner and form of payment for health care; the role of government in health care; and ethical concerns which affect provision of care. These issues and others are outlined more fully in the following section of this report.

PHASE II: POLICY PROPOSALS

Phase II of the HPA project, initiated in May, 1984 and scheduled for completion in the summer of 1986, is focusing on the development of specific policy proposals which are responsive to the issues and consistent with the HPA principles. A policy is defined as a general course of action or intended course of action deliberately adopted after a careful review of the issue and after a review of the possible alternatives. It is intelligently directed action toward consciously determined goals.

Each policy proposal will contain the following elements:

—A **definition of the issue** which succinctly describes the problem or opportunity, outlines the major causes of the problem, and frames questions to help guide policy development.

—A **goal statement** which describes the optimal outcome, condition, or relationship toward which policy should be directed;

—A description of the **basis of the policy**, including selected principles which govern policy direction, a historical review of past policies, and an analysis of the environment which affects policy choices.

—A description of the **proposed policy** or course of action and the rationale for its selection;

—An **implementation plan** which includes the initial necessary steps to bring the policy into being.

The policy development phase presents many challenges to the HPA participants. The HPA project must maintain the group consensus developed during Phase I and produce the kinds of creative insights necessary to address the issues identified in Phase I. In addition, it is imperative that the HPA develop internally consistent policies in a timely fashion in order to have a significant impact on the health care system in this country.

While there are significant challenges for the HPA, there are also immense opportunities. Never before has a policy planning effort of this magnitude been attempted by the private sector and never before has such a diverse group of individuals and organizations been brought together to analyze basic philosophies and to develop principles and policies for health care in the United States. When Phase II is completed, the many organizations will have a common basis, a shared perspective for responding to the complex of social, economic, scientific, educational, and political issues facing the health care system. The information presented in this report, Phase, I, has set the course for such a collaborative policy effort.

REPORT OF THE AD-HOC COMMITTEE ON MATERNAL AND CHILD HEALTH

Kenton Shaffer, M.D., Kearney - Chairman; **Section on Maternal Mortality Review:** George M. Adam, M.D., Hastings; Charles Field, M.D., Omaha; L. Palmer Johnson, M.D., Lincoln; William Rumbolz, M.D., Omaha; Bruce Taylor, M.D., Lincoln; Larry Wilson, M.D., Gothenburg; **Section on Perinatal Mortality Review:** Lawrence Bausch, M.D., Lincoln; Stacie Bleicher, M.D., Lincoln; Robert Grant, M.D., Lincoln; Robert Nelson, M.D., Omaha; Christine Markus, Omaha.

The committee has continued to meet on an intermittent basis this last year. Our efforts have dealt in two major areas.

We continue to review all maternal deaths in the state, under the direction of Dr. Rumbolz and his associates. These are discussed at various obstetric meetings in the state, as well as being presented in the Nebraska Medical Journal.

We continue to review infant mortality statistics — perinatal deaths in the state, in conjunction with the State Health Department. We have reviewed data from 1980 and 1981, and are in the process of reviewing data from 1982. We continue to have cooperation of most of the hospitals in the state. Recently, the University of Nebraska Medical Center has agreed to allow abstracting of charts of stillborns and neonatal deaths at UNMC.

Results of this data have been published by various members in brief reports in the Nebraska Medical Journal. The committee is in the process of developing guidelines with the Genetics Department at the University of Nebraska Medical Center about the evaluation of stillborn infants.

We are presenting data this year at the Nebraska Perinatal Association in conjunction with the Nebraska Medical Association meetings. This data is also used in outstate regional meetings.

REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

Warren Bosley, M.D., Grand Island - Chairman; Joseph R. Gard, M.D., Lincoln; John C. Goldner, M.D., Omaha; Paul Phillips, M.D., Scottsbluff; Eileen Vautravers, M.D., Lincoln; Wesley G. Wilhelm, M.D., Omaha; Gregg F. Wright, M.D., Lincoln; Douglas Cowen, Omaha.

The Ad-Hoc Committee on Health Education of the Nebraska Medical Association met on Thursday, March 21, 1985, at the Headquarters Office in Lincoln, Nebraska.

Doctor Vautravers was asked to report on the meetings of the Governor's Wellness Committee. She stated this Committee is working on developing recommendations to the State Health Coordinating Council concerning health promotion and that they are also developing criteria which will measure effectiveness. She urged that ideas from other groups be provided to the Committee.

There are seven areas in which the Committee is working: stress, nutrition, smoking/alcohol/drugs, hypertension, accident prevention, and fitness and exercise. It was suggested that the Nebraska Medical Association might assist in distributing material to patients to carry out the objectives of the Committee. It was further suggested that articles be solicited for the Nebraska Medical Journal to help physicians be more effective in prescribing exercise for their patients.

It was pointed out that smoking will be a major focal point in wellness and fitness programs. This Ad-Hoc Committee will review the goals of the Governor's Wellness Committee in this area. The Ad-Hoc Committee will obtain a list of resources for audio-visual aids which could be utilized for physicians in patient education, to include slides, photographs, and video tapes where office equipment permitted the use of these.

Members of the Ad-Hoc Committee believe that Wellness Programs have been effective in various parts of the state, especially Omaha and Lincoln, where absenteeism has been reduced with company-sponsored wellness and fitness programs.

The matter of routine physical examinations for junior and senior high athletes was discussed. It was noted that meetings will be held with Mr. James Riley of the Nebraska School Activities Association to develop guidelines and directives on how this might best be achieved. It was noted that most schools utilize the American Medical Associations format for the physical examinations for candidates for competitive sports.

AD-HOC COMMITTEE ON MEDICAID AND INDIGENT CARE

Dale Ebers, M.D., Lincoln - Chairman; Eugene J. Barone, M.D., Omaha; Judith Butler, M.D., Superior; Wm. H. Johnson, M.D., Omaha; Jack Mathews, M.D., Lincoln; Frederick F. Paustian, M.D., Omaha; Craig Urbauer, M.D., Lincoln.

This committee was constituted by Dr. Peetz and continued by Dr. Reese and came out of a concern of what was going to happen in the area of Medicaid when the Legislature froze physician fees for that program for a period of 2½ years. With the freeze on fees and the increasing cost of providing those services due to continuing inflation, it became apparent in early 1983 that soon the physician provider would be very close to only receiving his overhead from the Social Services Department for Medicaid care. At about that time, most physicians were receiving about 67% of billed charges. With most primary care physicians' overhead running somewhere between 45-55%, obviously this was a very slim margin. At that time, the Unicameral had frozen the fees for another year and the total appropriation for the Medicaid program was also frozen. It therefore appeared that the percentage of billed charges would continue to fall and at some point physicians would decide that it was too expensive for the individual physician to provide services for Medicaid patients.

The Committee then, along with or parallel to the Social Service Department, began investigating other options and delivery systems which might make it possible for the participating physicians to be rewarded financially more equitable. A number of other HMO concept programs, which were pilot projects throughout the United States, were reviewed and studies by both this Committee Chairman and the Social Services Department trying to develop a program that might function in the State of Nebraska. Early it was decided that trying to cover the whole state with a program like this was being overly optimistic and so the program focused on Lancaster County as a pilot project.

To develop one of these programs also required a waiver from the Federal Government because any of these open paneled HMO concepts would have required that the patient give up their choice of provider, which is in the Federal statutes. With the passage of a year or so, the various pilot projects about the United States developing more and more difficulties and being not nearly as productive and effective as was projected, the Federal Government became less and less inclined to give this waiver to Medicaid agencies. At the same time, the number of hospital days provided per Medicaid population in the State of Nebraska was falling rather dramatically even without the institution of any DRGs or other regulatory mechanisms. For any of these systems to work and shift monies to physicians for their services, they would have to decrease hospital days to free up that kind of monies.

In our reviews and studying of these situations and pilot projects, it also became apparent that physician groups such as the Nebraska Medical Association or County Medical Societies can not sponsor such a project without being at odds with the Federal Trade Commission laws and rules. On the other hand, the Social Services Department feels that it would be very difficult and cumbersome for them to develop an administrative system within the department without increasing their total employees, which is contrary to the wishes of the last three administrations.

At this point, then, it would appear that for this type of project to be initiated an insurance company or the Blues or some other administrative unit would have to be interplaced to initiate an HMO concept for Medicaid recipients.

Currently, the Social Services Department has collected a great deal of information and have developed some concepts as to where they might go if this becomes an appropriate option. The Medical Association really has nothing that it can provide legally other than to be available to participate in this kind of a program if one is developed outside the medical profession. Paramount to all of this is the reluctance at this point of the Federal Government to issue the waivers which would allow such a project even to be instituted.

Easing the financial pressures on the physician providers are the facts that the freeze on physician fees has terminated and that as of October 1, 1984, a 7% increase in physician fees was allowed through the Social Services Department.

Considering all the above facts, the Committee is currently at a stalemate and perhaps is no longer a useful committee for the NMA.

REPORT OF THE TASK FORCE ON ALTERNATE HEALTH PLANS I

C. J. Cornelius, Jr., M.D., Sidney - Chairman; Warren Bosley, M.D., Grand Island; Dale Ebers, M.D., Lincoln; Vernon F. Garwood, M.D., Lincoln; Richard Meissner, M.D., Omaha; Donald J. Pavelka, M.D., Omaha; Michael Haller, M.D., Omaha; Roger D. Mason, M.D., Omaha

The Task Force has held two meetings and considered a number of reports and opinions regarding a possible role for the NMA in an alternate Delivery System, namely an Association IPA. We met with and reviewed material received from legal counsel regarding the constraints of the Federal Trade Commission on such an endeavor and explored a possible role for the NMA in the Medicaid program. A preliminary structure for the Medicaid program was developed under the name of Nebraska MEDNET and was submitted for legal review. This structure would involve the development of an IPA program by Nebraska Blue Cross-Blue Shield who would make a bid for the provision of physician services to the State's Medicaid population and then develop an agreement with physicians to provide these services via an Alternate Delivery System and would administer an equitable distribution on contract funds through a reimbursement formula.

Nebraska Blue Cross-Blue Shield is currently developing an Alternate Delivery System to be offered to Nebraskans later this year and will enlist physicians for this program. Some preliminary discussions have been carried out with them regarding the use of this type structure to provide the vehicle for a Medicaid bid. In as much as any Medicaid program would be administrated as an "administrative services only" contract, they are currently concentrating their efforts on their competitive commercial program targeted for implementation around July 1, 1985, and although they have exhibited some interest in a Medicaid bid they are not anxious to spend a lot of time and effort on this program until after the other program is up and running.

The Task Force has concluded that the possibility of the NMA acting as a vehicle for or actually developing an IPA of Association members is not viable at this time under the current FTC regulations. Since the NMA's membership is well in excess of 50% of the state's physician population, an Association IPA would constitute a monopoly under Federal rules. We recommend that the NMA continue to pursue the possibility of a Medicaid arrangement via a third party insurer and that the Board have discussions with the Department of Social Services and investigate the necessity of legislative changes to permit such a program to operate. It is further recommended that the NMA monitor possible changes in FTC Regulations which might make it possible for the Association to consider a possible Alternate Delivery System in the future.

Your Task Force is impressed that almost any Corporate structure could put together an HMO and contract with physicians to provide medical care to its subscribers, but a major physician organization is restrained from doing so. Possible changes in the FTC Regulations have been rumored, but to date none have occurred.

Copies of the "MEDNET" proposal and legal counsel's comments are appended to this report. In reviewing this material, please keep in mind that this structure was submitted as a starting point only and was not reviewed or approved by the Board of Directors of the NMA prior to its submission.

NEBRASKA MEDNET

The purpose of this organization, a statewide network of physicians, shall be the provision of medical care via a contractual agreement with a private health insurance company to those persons whose medical care is underwritten by the Nebraska Department of Social Services. This medical care shall be provided through primary care physicians who will provide "case management" for each recipient and all medical referrals must be approved and arranged by these case managers.

The specific provisions of the medical insurance contract shall be agreed upon by the Department of Social Services and the health insurance company and also between the health insurer and the representatives of Nebraska MEDNET.

The objective of this contractual agreement is not to increase the amount of money expended by the Department of Social Services but rather to provide more efficient and cost effective medical services. It is contemplated that certain economies can be realized both by the case management approach and by the efficient performance of the private health insurer.

A primary care physician, for the purposes of this organization, shall be so designated after successful application to the Board of Directors of MEDNET and shall agree to perform the following:

1. Provide basic medical services and case management to patients eligible to receive care underwritten by the Nebraska Department of Social Services.

2. Respond to inquiries, requests and emergencies of eligible recipients under his case management and pay for backup physician services when he is not available for whatever reason.

3. Arrange for appropriate referral for necessary specialty care in accordance with the agreed upon referral mechanism for patients for whom he has been designated as case manager.

Case management agreement shall be for a period of 1 year but may be altered by a decision of the Board of Directors in the event of a significant controversy or incompatability between physician and patient. Physician members of MEDNET may limit the number of cases for whom they provide care management with the approval of the Board of Directors. The Board of Directors may prescribe a minimum number of patients which a physician must accept for case management if necessary to assure an equitable distribution of cases in a given locality or community.

Payment for basic physician services will be made on a capitation basis and reimbursement for procedural services shall be on the basis of the UCR of the insurer utilizing the 75th percentile. A 5% service fee shall be retained by the Board of Directors for all medical services. These funds will be kept in reserve by the Board in an appropriate FDIC insured account to be used to defray the expenses of the Board and to be distributed to MEDNET physician members in the event of a favorable cost experience at the end of each contract year. Successful cost containment may well hinge on the development of a cost effective referral network of specialists who will agree to participate on a UCR basis during the 75th percentile as a basis for payment in full.

Cline, Williams, Wright, Johnson & Oldfather
Office Memorandum

TO: Nebraska Medical Association
FROM: Pamela Hastings Carrier
DATE: October 3, 1984
RE: Nebraska MEDNET

I have reviewed the general outline of the organization of Nebraska MEDNET and believe that the general concept of this contractual agreement to provide medical services to those individuals served by the Nebraska Department of Social Services is in compliance with the anti-trust laws of the state and federal government.

I am assuming that MEDNET is a corporation with its stockholders or members being either providers or representatives of health providers. The membership or participation in MEDNET should not be restricted other than on a basis of reasonable criteria to ensure quality of care or financial participation. We will need to discuss further as to whether MEDNET should be set up as a for profit or a not for profit corporation. Those physicians, or other health care providers, participating in MEDNET should be required to make a capital contribution to MEDNET or there should be substantial risk sharing to be undertaken by the participants.

One of the aspects that would make this proposal comply with the anti-trust laws would be that the capitation rates for each patient would be determined either by the Department of Social Services or a participating private health insurance company. MEDNET should not establish a price schedule as between MEDNET and either the insurance company or the Department of Social Services. From my research, it does not appear that there is any problem with MEDNET setting out fee schedule for distribution of the monies received from either the Department of Social Services or the private insurance company. From the sources that I have consulted, this would be considered as a distribution of revenues which is legal for corporations. I might interject one caveat, there may be a danger of establishing a fee schedule within MEDNET if this fee schedule is then used by the doctors for their private paying patients. MEDNET should take all reasonable action to indicate that any fee schedule established by MEDNET should only be used for purposes of distributing the MEDNET fees. If a fee schedule exists which has been jointly prepared by competing physicians and then such a schedule is used by the competing physicians it would be difficult to argue that there was not a conspiracy among competitors to fix prices.

The two criteria that would cause an organization like MEDNET to be considered an integrated practice among the various doctors participating, and thus more likely to avoid antitrust liability, would be 1) substantial contribution of capital and 2) undertaking substantial financial risks. If MEDNET can show that it is an organization of physicians who have partially integrated their practices for purposes of participating in MEDNET, then we can get past a **per se** classification of the arrangement and the rule of reason under the antitrust laws will apply. Once the rule of reason applies, then the consideration is whether or not the arrangement has an anticompetitive purpose.

In setting up MEDNET, one of the considerations is that we not restrict the doctors participating in MEDNET from participating in any other alternative provider system.

Another aspect of this arrangement which will most likely make it clearly outside the antitrust prohibitions is the fact that it will most likely be state regulated. I am anticipating that there would need to be a change in the state statutes providing that the Department of Social Services can contract with HMO-like organizations for providing the necessary medical care to its recipients. I would anticipate that any statutory provision providing for such contracting would need to be drafted such that other organizations besides MEDNET, an organization sponsored by the Nebraska Medical Association, would be permitted to contract with the Department of Social Services. At this time, I would suggest that any contract that MEDNET might execute with the Department of Social Services be limited in the time in which it would be effective. A shorter time for contracting would be less likely to be held to be in violation of the antitrust laws.

It is my opinion that the proposal for Nebraska MEDNET presented to me is a viable alternative and could be structured to avoid any conflict with antitrust laws. It appears to me that the next step in analyzing this type of proposal would be to contact a representative of a private health insurance company who is familiar with the necessary management operations of a similar type program such that they may advise us as to the economic feasibility of such an arrangement. Additionally, we may want to early on involve the Nebraska Department of Social Services and request their input. Without further investigation of the laws and regulations with regard to reimbursing health care providers under the Medicaid Program in Nebraska, I am anticipating that we would need to begin working with the legislature in order to draft and have adopted the necessary enabling statutes.

At the present time, I am continuing to gather materials to provide an understanding as to other programs that are operating as alternative provider systems throughout the country. I will continue to gather this information and perahps the experiences of other organizations can be incorporated in any Nebraska MEDNET proposal.

Board of Councilors

The Annual Session meeting of the Board of Councilors was held on Friday, April 26, 1985, at the Cornhusker Hotel, Lincoln, Nebraska.

Members present were Drs. Stanley Truhlsen, Howard Dinsdale, C. T. Frerichs, Roger Massie, William Chleborad, Thomas Wallace, Warren Bosley, George Lytton, R. E. Donaldson, Herbert E. Reese, Francis Donahue and Dwaine J. Peetz.

The meeting was called to order by the Chairman, Dr. Truhlsen.

Dr. Truhlsen called for approval of the minutes of the Fall Session meeting of the Board of Councilors as printed in the December, 1984, issue of the Nebraska Medical Journal. These were approved as printed.

The Board then reviewed the reports and resolutions contained in the Handbook. Following discussion regarding these reports and resolutions, these were accepted for referral to the House of Delegates for consideration.

The Councilors reviewed the requests for Life Membership, and these were approved for referral to the House of Delegates.

Following review of cases which had been received since the Fall Session, the meeting was adjourned.

House of Delegates

FIRST SESSION

The first session of the House of Delegates was held on Friday, April 26, 1985, at the Cornhusker Hotel, Lincoln, Nebraska.

The meeting was called to order by the Speaker, Dr. McFadden. A call for quorum showed that 88 delegates were present, and the House was declared in session.

The Speaker called for any changes in the seating of delegates, and these requests were approved.

The House recognized the following Fifty Year Practitioners:

Paul M. Bancroft, M.D., Lincoln
John G. Brazer, M.D., Omaha
Julius B. Christensen, M.D., Omaha
Carl J. Formanack, M.D., Syracuse
Clarence M. Hartmann, M.D., Omaha
James F. Kennedy, M.D., Alliance
William R. Kovar, M.D., Omaha
Maurice M. Steinberg, M.D., Omaha

The following Fifty Year Practitioners were unable to attend:

Wayne M. Hull, M.D., St. Petersburg, Fla.
Frank J. Iwerson, M.D., Omaha
Wilbur A. Muehlig, M.D., Omaha
John A. Rosenau, M.D., Scottsbluff
Robert S. Wigton, M.D., Omaha

Dr. McFadden called for oral reports and the following were presented:

Chas. Dobry, M.D., Interim Dean, University of Nebraska Medical Center
Michael Haller, M.D. reported on the activities of Creighton University School of Medicine
F. Wm. Karrer, M.D., Chairman, Nebraska Tumor Registry
John D. Coe, M.D., Medical Director, Nebraska Foundation for Medical Care
Russell L. Gorthey, M.D., Chairman, Health Gallery Committee
Luke Lemke, President, NMA-MSC

Dr. McFadden called for approval of the minutes of the Fall Session meeting of the House as published in the December, 1985, issue of the Nebraska Medical Journal. These were approved as printed.

The following Reference Committee assignments were made:

REFERENCE COMMITTEE #1
- Annual Audit
- Report of the Board of Directors - Budget
- Report of the Commission on Association Affairs
- Report of the Board of Directors — Items #3, #4, #5, #6, #7, #8 and #9

REFERENCE COMMITTEE #2
- Report of the Delegate to the AMA
- Report of the Commission on Hospital Medical Staff
- Report of the Board of Directors — Items #1, #2 and #10
- Resolution #4 — Metro Omaha — Doctor Jerald Schenken Candidacy
- Resolution #5 — Metro Omaha — Graduate Medical Education Payment Under Medicare
- Resolution #8 — Buffalo, Hall and Adams Counties — Changing Atmosphere in Health Care Delivery

REFERENCE COMMITTEE #3
- Report of Creighton University School of Medicine
- Report of the University of Nebraska College of Medicine
- Report of the Nebraska Medical Foundation
- Report of the State Department of Health
- Report of the Ad-Hoc Committee on Health Education
- Resolution #1 — NMA-MSC — Proposed Cuts in Student Aid
- Resolution #7 — Lancaster County — Nebraska Hospitals' Participation in the Nebraska Tumor Registry

REFERENCE COMMITTEE #4
- Report of the Nebraska Foundation for Medical Care, Steering Committee
- Report of the Committee on Health Planning
- Report of the Ad-Hoc Committee on Medicaid and Indigent Care
- Report of the Task Force on Alternate Health Plans I

REFERENCE COMMITTEE #5
- Report of the Commission on Legislation and Legal Affairs
- Report of the Commission on Public Affairs
- Report of the Board of Directors — Item #11 — Long Range Planning
- Resolution #6 — Dodge County — Malpractice Quotation by AMA Official

REFERENCE COMMITTEE #6
- Report of Task Force, Inter-Relationships & Interprofessional Cooperation
- Report of the Ad-Hoc Committee on Maternal and Child Health
- Requests for Life Membership
- Resolution #2 — Metro Omaha — Low-Level Radioactive Waste Disposal Act of 1980
- Resolution #3 — Metro Omaha — A.M.A. Legal Action

The following Nominating Committee was selected and approved by the House:

1st District — Dr. John Mitchell, Omaha
2nd District — Dr. Robert Osborne, Lincoln
3rd District — Dr. Joseph Hermsen, Beatrice
4th District — Dr. Gary Smith, Newman Grove
5th District — Dr. A. H. Bergman, Fremont
6th District — Dr. Richard Pitsch, Seward
7th District — Dr. Robert Quick, Crete
8th District — Dr. Thomas Wallace, Gordon
9th District — Dr. Richard Hranac, Kearney
10th District — Dr. David Little, Hastings
11th District — Dr. Berl Spencer, Ogallala
12th District — Dr. Robert Morgan, Alliance

No further business was presented to the House, and following executive session, the House was recessed until Sunday morning.

SECOND SESSION

The second session of the House of Delegates was held on Sunday, April 28, at the Cornhusker Hotel, Lincoln, Nebraska.

The meeting was called to order by the Vice Speaker, Dr. Armstrong. A call for a quorum showed 69 delegates present, and the meeting was declared in session.

Dr. Armstrong called for approval of the minutes of the first session, and these were approved as printed.

Mrs. Helen Krause, Immediate Past President of the NMA Auxiliary, presented the AMA-ERF checks to Dr. Harry McFadden, representing the University of Nebraska College of Medicine and to Dr. Michael Haller, representing the Creighton University School of Medicine.

Dr. Howard Dinsdale, President of the Nebraska Medical Foundation, presented the NMF Student Research Scholarship Program checks, each in the amount of $1,000, to Donald L. Jacobs of the University of Nebraska Medical Center, and to Sheri Y. Nottestad of the Creighton University School of Medicine.

Oral reports were presented as follows:

Mrs. Helen Krause, Immediate Past President, NMA Auxiliary

Dr. Gregg Wright, Director, State Department of Health
Dr. Herbert E. Reese, President, NMA

Reports of the Reference Committees were presented as follows:

Reference Committee #1

Reference Committee #1 considered four reports. The Reference Committee submits the following report and recommendations.

(1) ANNUAL AUDIT REPORT

The Annual Audit was reviewed and important items were discussed by members of the administrative staff and Treasurer. No additional comments were received. It is noted that the growth in expenditures was less than 4% and that the recent dues increase had reduced the 1983 general fund deficit of $50,337 to $6,504 for 1984. In addition, the reserve fund is growing on the basis of interest income at a rate which allows it to maintain the required 75% of a year's budget. The Committee recommends approval of the Audit Report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE BOARD OF DIRECTORS — BUDGET

The budget increase is approximately 4% over the 1984 budget and no dues increase is required. There are no major changes in specific items from the previous year. The Committee recommends approval of the 1985 budget.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

The Committee discussed amendments to the By-Laws which provide for an additional delegate and alternate delegate to the American Medical Association to serve in the event that the Nebraska Medical Association has over 75% of its membership which belong to the American Medical Association. These delegate and alternate slots may or may not be available depending on annual changes in membership. The proposed amendments would allow the Board of Directors to select one of the AMA alternates to serve as the additional delegate and the Board would designate the President as an alternate and the President-Elect or the Secretary-Treasurer to serve as the additional alternate. This proposal would save approximately $4,000 per year by selecting individuals who are already attending the AMA meeting.

Amendment to Chapter VII, Section 1 (1)

Except as hereafter provided, delegates to the American Medical Association, and their alternates, for terms of two years each but not to exceed five consecutive two-year terms after May, 1978; provided, however, for good cause shown, the House of Delegates may elect to retain an AMA Delegate or Alternate on a year-to-year basis. **If at any time Nebraska is permitted by the AMA to have one additional Delegate and one additional Alternate based upon Nebraska's fulfillment of criteria relating to percentage membership in the AMA, the Board of Directors shall select one of the AMA Alternates to serve as the additional Delegate and the Board of Directors shall designate the President as an AMA Alternate and shall select either the President-Elect or the Secretary-Treasurer to serve as the additional Alternate.**

Amendment to Chapter VIII, Section 6

Members of the Board of Directors may not hold two elected positions at the same time; **provided, however, this shall not prohibit the President, President-Elect or Secretary-Treasurer to serve as the additional alternate to the American Medical Association as provided in Chapter VII, Section 1 (1).**

Amendment to Chapter IX, Section 1

(11) Serve as the AMA Alternate to the American Medical Association, if so designated, as described in Chapter VII, Seciton 1 (1). (Renumber current subsection (11).

Amendment to Chapter IX, Section 7

(9) Serve as the additional Alternate to the American Medical Association, if so designated, as described in Chapter VII, Section 1 (1).

Amendment to Chapter IX, Section 2

(9) Serve as the additional Alternate to the American Medical Association, if so designated, as described in Chapter VII, Section 1 (1).

Amendment to Chapter X, Section 1 (14)

(14) Fill vacancies occurring in any offices and in Delegates to the American Medical Association and their Alternates, subject to the approval of the House of Delegates at its next regular session except if filled pursuant to Chapter VII, Section 1 (1).

The Reference Committee recommends approval of the By-Law changes.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) LIFE MEMBERSHIP BENEFITS

The Commission on Association Affairs recommends review of criteria for Life Membership. It recommends that Life Members be charged a minimal fee for the Nebraska Medical Journal with the option of not taking the Journal. Such a change would require By-Law revisions which could be considered at the Fall Session. The Reference Committee heard discussion of the advantages and disadvantages of such change. The major advantage would be a savings of approximately $3,600 per year just to supply the Journal for Life Members. The anticipated fee was approximately $20.

The Reference Committee recommends that Life Members be charged a minimal fee for the Nebraska Medical Journal with the option of not taking it.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) ASSOCIATE MEMBER CATEGORY IN THE NEBRASKA MEDICAL ASSOCIATION

The Commission on Association Affairs recommends that a new membership category designated Associate Member be created. Testimony established that there had been a recent request for such membership and it was anticipated that a tendency toward earlier retirement might increase such requests. There was no testimony in opposition.

The Reference Committee recommends approval of the establishment of an Associate Member category for persons who retire from medicine and do not pursue another medically-related career, and do not receive any compensation relative to their M.D. degree, and do not meet the criteria for Life Membership status, and would be eligible for an Associate status if they retire after 25 years. The Associate Member would pay for the services from the NMA such as the Journal, mailings, etc. Creation of such a category would require Article and By-Law changes which would need to be considered at a future session of the House of Delegates.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(6) MEMBERSHIP BENEFITS

The Commission on Association Affairs is doing an in-depth study of various benefits that the NMA membership could provide. The purpose of providing benefits is to encourage membership. Types of benefits under consideration include insurance, retirement plans, magazine subscriptions, generic contract analysis by legal counsel, group purchasing, computer services, and reciprocal memberhsip through the Association in private clubs. The Commission solicits comment from the membership regarding such benefits and benefit packages. Testimony before the Reference Committee included concerns about providing appropriate services which would entice young physicians, especially those in alternate delivery systems to join the Nebraska Medical Association. Testimony appeared favorable to the general concept.

Recommendations:

1. The Reference Committee recommends continuation of the study regarding membership benefits.

2. The Committee recommends that members of the House of Delegates comment individually to the Committee regarding such benefits.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(7) REPORT OF THE BOARD OF DIRECTORS — ITEMS #2, #4, #5, #6, #7, #8 and #9

These items involved recommendations which were referred to the Commission on Association Affairs and were subsequently covered in the Commission on Association Affairs' report. Item #9 recommended reinstitution of a registration fee for the Annual Session. Such registration fee has been instituted. The Reference Committee received no comments on these items. The Reference Committee recommends that the items be received for information only.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF YOUR REFERENCE COMMITTEE #1 REPORT AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Dr. Robert L. Kruger, Omaha - Chairman
Dr. James Carson, McCook
Dr. Thomas Wallace, Gordon

Reference Committee #2

Reference Committee #2 considered three reports and three resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE DELEGATE TO THE AMA INTERIM MEETING

The Reference Committee heard discussion on the Nebraska resolutions #5 and #4 each of which was referred to the Board of Trustees for consideration. Resolutions #6 and #7 were adopted. Resolution #39 by Dr. Cornelius was considered with four additional resolutions and combined into a substitute resolution that the AMA continue to support professionally directed programs in medical peer review.

Multiple resolutions were submitted in opposition to the sport of boxing by medical societies and professional associations. This opposition to the sport of boxing was endorsed by the Nebraska delegate to the AMA.

The subject of unified membership was again discussed and alternatives suggested to the high cost of dues to the three levels of membership and to apply some adjustment in these dues mechanisms in order to attract additional members.

Review of the Foreign Medical Graduates was again undertaken and it was noted that the changes in the immigration laws had changed and at this time, the number of Foreign Medical Graduates engaged in graduate medical education is at an all time low. However, there were 111,161 foreign medical graduates in the U.S.A. in 1983.

There was a considerable interest in the joint venturing of medical staff and hospitals that could result in exclusion of other members of the medical staff. The AMA delegate is concerned that this issue may be the first issue in a battle between hospital medical staffs and the hospital governing boards. Close observation of this activity is imperative.

Resolution #4 from the Metro Omaha Medical Society was combined with the final item of the AMA delegate report and concerned the endorsement of Doctor Jerald Schenken's candidacy to the position of member of the Board of Trustees of the American Medical Association. Approval for Doctor Schenken included the Nebraska Medical Association, the College of American Pathologists, and the North Central Medical Conference. There is considerable activity in the support of Dr. Schenken from specialty societies and Nebraska would be honored to have Dr. Schenken as a member of the Board of Trustees of the American Medical Association. Resolution #4 reads as follows:

> WHEREAS, at the urging of his friends, his local Society, the College of American Pathologists, and many individuals of influence in the American Medical Association, Doctor Jerald Schenken has consented to be a candidate for the Board of Trustees of the American Medical Association, and
>
> WHEREAS, his candidacy is a natural outcome of his ability, his interest in the problems facing our profession, and his considerable skills as a spokesman for medicine,and
>
> WHEREAS, his successful candidacy would bring great honor to our profession, state and the Nebraska Medical Association;
>
> THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association, with pride and enthusiasm, endorses the candidacy of Doctor Jerald Schenken to the position of member of the Board of Trustees of the American Medical Association.

Recommendation:

Your Reference Committee commends Dr. Coe on an excellent report of the Interim Meeting of the American Medical Association and extends its appreciation to all members of the Nebraska Medical Association delegation in their continued efforts on the behalf of Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS

SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE COMMISSION ON HOSPITAL MEDICAL STAFF

The Committee heard comments relating to the credentialing of medical hospital staffs following the recent publication of JCAH Regulations. In addition, clinical privileges for physicians was discussed and it was announced that there will be a meeting of the combined Nebraska Medical Association and Nebraska Hospital Association on the subject of credentialing and medical privileges, set for September 5, 1985. Additional information will be forthcoming.

An item of concern was the networking of hospital and physician offices that is currently occurring within Nebraska and its ramifications. The Commission anticipated consultation with hospitals, physicians, and for the medical staff relationships in the ongoing, ever changing area of health care delivery.

Recommendation:

Your Reference Committee recommends acceptance of the report of the Commission on Hospital Medical Staff and urges the membership to pay clcse attention to this important Commission activity as it effects the delivery of medical care in the State of Nebraska and its effect on the membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) BOARD OF DIRECTORS - ITEMS #1, #2 and #10

Item #1 indicated the membership's displeasure with the inferences contained in letters to patients by the American Family Insurance Company pertaining to physicians' fees. It was noted that South Dakota had instituted some form of action against the company to criticize such actions. The NMA has submitted the matter for review by legal counsel. Item #2 of the Board report indicated that an SRI survey was carried out through the membership to identify items of concern of the membership. These responses were referred to the various committees and commissions for their review and suggestions.

Item #10 again supported the candidacy of Dr. Jerald Schenken and approved a financial contribution of $5,000 to assist in covering the cost of the election. Dr. Schenken wanted to convey to the membership his thanks for their support and especially the support of Jan, Nancy, Mary, Bobbie, Ken and Bill, in their continued efforts in behalf of his candidacy.

Recommendation:

Your Reference Committee recommends the adoption of these items in the report of the Board of Directors.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) RESOLUTION #5 — METRO OMAHA — GRADUATE MEDICAL EDUCATION PAYMENT UNDER MEDICARE

This resolution reads as follows:

WHEREAS, there are several proposals to alter the payment for indirect costs of graduate medical education under Medicare, and

WHEREAS, the current payment schedule was specifically designed by Congress to deal with case mix and intensity of care in addition to education expenses;

BE IT RESOLVED, that the Nebraska Medical Association support the AMA in their statement that "until an appropriate alternative is developed, the AMA strongly supports the current system for financing graduate medical education costs through patient care revenues from third-party payors including Medicare."

Considerable testimony was heard relating to the low compensation level that had been received by all physicians for medicare and medicaid payments. Testimony supported the AMA position that graduate medical education costs be funded through patient care revenues to include Medicare. It was further noted that the Nebraska Legislature had abandoned their responsibility in providing funding for medical education and their failure to provide funding for medical care of indigents.

Recommendation:

Your Reference Committee supports the resolution's intent and the AMA position.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #8 — BUFFALO, HALL AND ADAMS COUNTY MEDICAL SOCIETIES — CHANGE IN ATMOSPHERE IN HEALTH CARE DELIVERY

The resolution reads as follows:

WHEREAS, outstate physicians in central Nebraska have enjoyed excellent rapport and service from metropolitan physicians, and

WHEREAS, in the last several years many excellent young specialists have established practices in central Nebraska and our hospitals and have made most sophisticated diagnostic modalities available on a regional basis, and

WHEREAS, metropolitan hospitals are attempting to expand and provide services in central Nebraska that can already be provided:

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association,through the Commission on Hospital Medical Staffs, begin discussion and dialogue with hospital boards, hospital administrators, and physicians in the state on these issues.

This subject indicated multiple concerns on the part of physicians in central Nebraska relating to the encroachment in their area of sophisticated diagnostic modalities and the attempt of metropolitan hospitals to expand and provide these services throughout Nebraska. It was recommended that a task force be formed for the study of competitive aspects that are now occurring in this realm and for the concern of quality of the services provided and the quality of local resources. It was a general concern for evolving events in medical practice as it pertains to the specialty activities from the metropolitan areas.

Recommendation:

The Reference Committee recommends that a forum be established to sponsor discussions through the NMA and to inform hospital administrators of the physicians concerns and to study the relationships between the physicians providing the service and the communities receiving the services. It is the feeling of the Committee that this is an item of considerable concern and that priority be given to the analysis of the various problems involved and to refer this activity to the Commission on Hospital Medical Staff for implementation.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS

SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2 AS A WHOLE. This was seconded. There was discussion concerning the Reference Committee's use of the word "abandoned" in the last sentence of the first paragraph in Item #4. A motion was made by Dr. Schenken that this last sentence be deleted, and this was approved. The report of the Reference Committee was then adopted as amended.

Respectfully submitted
Dr. Orin R. Hayes, Lincoln - Chairman
Dr. Ronald Asher, North Platte
Dr. L. Thomas Heywood, Jr., Papillion

Reference Committee #3

Reference Committee #3 considered five reports and two resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE
REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

The report of the Creighton University School of Medicine submitted by Dr. O'Brien was received for information. It was considered in conjunction with oral remarks given by Dr. Haller on the floor of the House of Delegates. It is recommended that this report be approved as submitted.

The report of the University of Nebraska College of Medicine as submitted by Dr. Dobry was received for information. It was considered in conjunction with the remarks made by Dr. Dobry on the floor of the House of Delegates. It is recommended that this report be approved as submitted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE NEBRASKA MEDICAL FOUNDATION

The Committee then considered the report of the Nebraska Medical Foundation. There was discussion in the Reference Committee relative to the student loan program and it was specifically pointed out that the Foundation has been most successful in its loan repayment program and the default rate is extremely low.

Considerable discussion was heard relative to the Tumor Registry. This discussion was held in conjunction with the discussion on Resolution #7 from Lancaster County relative to Nebraska hospitals participation in the Nebraska Tumor Registry. Resolution # 7 reads as follows:

> WHEREAS, the Nebraska Medical Foundation has an important role in the development of the Nebraska Tumor Registry, and
>
> WHEREAS, the Nebraska Tumor Registry has developed a uniform method of reporting data for hospitals, and
>
> WHEREAS, the Nebraska Tumor Registry provides a valuable service to the citizens and medical community of Nebraska;
>
> THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association continue to encourage all hospitals in Nebraska to participate in the Nebraska Tumor Registry.

It was pointed out that the voluntary registry being administered by the Nebraska Medical Foundation is theoretically quite close to its goal and if a few of the larger, prominent institutions in the state were to actively participate in the Registry that the voluntary effort of the Foundation would be highly successful.

The Reference Committee would like to submit Resolution #7 as modified:

> WHEREAS, the Nebraska Medical Foundation has an important role in the development of the Nebraska Tumor Registry, and
>
> WHEREAS, the Nebraska Tumor Registry has developed a uniform method of reporting data for hospitals, and
>
> WHEREAS, if this voluntary system is not effective, then mandatory state-regulated tumor registration will occur, and
>
> WHEREAS, the Nebraska Hospital Association has supported the concept of a voluntary tumor registration;
>
> THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association continue to encourage all hospitals in Nebraska to participate in the Nebraska Tumor Registry.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Hayes urged each physician to encourage his hospital to participate in this Tumor Registry if they are not already doing so. This section of the report was adopted.

(3) REPORT OF THE STATE DEPARTMENT OF HEALTH

The Reference Committee then considered the report of the State Department of Health submitted by Dr. Wright, the Director. This report was received for information. The Reference Committee recommends approval of this report as submitted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

The Reference Committee then considered the report of the Ad-Hoc Committee on Health Education chaired by Dr. Bosley. This report was received for information. The Reference Committee wishes to commend Dr. Bosley and the members of this Ad-Hoc Committee for their efforts in this timely and important educational endeavor. It is felt that this type of educational effort reflects favorably upon the entire medical community and provides a significant service to the citizens of the State of Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #1 — NMA-MSC — PROPOSED CUTS IN STUDENT AID

The Reference Committee then considered Resolution #1 from the Medical Student Chapter of the Nebraska Medical Association relative to proposed cuts in student aid, which read as follows:

> WHEREAS, President Reagan's Fiscal Year '86 budget proposal contains cuts in federal student aid which, if enacted, will cause extreme restructuring of most student aid programs, and
>
> WHEREAS, identified within these proposed cuts

are numerous aid programs for which funding will be eliminated or reduced that would have serious implications for the medical students of the State of Nebraska;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association, by whatever means it deems most effective, contact Nebraska's Congressional representatives in opposition to President Reagan's Fiscal Year '86 budget proposal to cut federal student aid for medical students.

There was considerable discussion from representatives of the Medical Student Chapter relative to the impact of proposals which would decrease the amount of available loan funds for medical education.

The Reference Committee wishes to submit the following modified resolution:

WHEREAS, President Reagan's fiscal year '86 budget proposal contains cuts in federal student aid which if enacted will cause restructuring of most student aid programs, and

WHEREAS, these proposed cuts would have serious implications for the medical students for the State of Nebraska, and

WHEREAS, a majority of medical students at UNMC and Creighton University require financial aid in support of their medical education costs, and

WHEREAS, many worthy students may be prevented from obtaining a medical education by these proposals, and

WHEREAS, this proposed reduction in student loan funds represents another aspect of decreased federal support for medical education, and

WHEREAS, Medicare and Medicaid funds are being restricted from use in both undergraduate and graduate medical education;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association convey its concern about decreasing federal financial support for medical education to the House of Delegates of the American Medical Association and to the Nebraska Congressional delegation, and

BE IT FURTHER RESOLVED, that the American Medical Association study this issue and its impact in depth in order to be able to provide suitable recommendations to Congress.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #3 AS A WHOLE. This was adopted by the House.

I wish to thank Dr. Paustian and Dr. Doering for their input and assistance in this Reference Committee.

Respectfully submitted,
Dr. Craig Urbauer, Lincoln - Chairman
Dr. William Doering, Franklin
Dr. Frederick Paustian, Omaha

Reference Committee #4

Reference Committee #4 considered four reports. The Reference Committee submits the following report and recommendations.

(1) NEBRASKA FOUNDATION FOR MEDICAL CARE STEERING COMMITTEE

The discussion centered around three subjects, the first was the controversy about the 5,000 cases that were identified as a backlog. Considerable discussion ensured but the reason for the backlog was not clarified because of lack of information. The second item of discussion was the inconsistency of reviewers. An explanation was made that an attempt is being made to standardize insofar as possible the quality of the reviewers. It was pointed out that the InterQual Standards were mostly used by the coordinators and not by the M.D. reviewers. The third item of discussion was the charge for the duplication of records in small hospitals which poses a burden on their finances. It was brought out that hospital records when submitted for review had to be complete. In addition, for physician reviewers to travel to small hospitals, was too expensive, so the solution was not forthcoming. Discussion revealed that more M.D. reviewers are probably needed.

Recommendation:

It is the recommendation of the Reference Committee #4 that the Report on the Nebraska Foundation for Medical Care Steering Committee be accepted with a recommendation that special attention be directed to the controversial areas.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) COMMITTEE ON HEALTH PLANNING

There was no discussion on this report. We recommend that the report of the Committee on Health Planning be accepted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) AD-HOC COMMITTEE ON MEDICAID AND INDIGENT CARE

The discussion revolved around the fact that the HMO concept for Medicaid and Medicare was not viable at this time and this was brought out in the report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) TASK FORCE ON ALTERNATE HEALTH PLANS I

The discussion on this report centered around the fact that there is a great change occurring in alternate health plans which eventually will probably eliminate the solo physician. It was brought out that as a society, we cannot form a health care plan because it would be considered a monopoly. It was suggested that the Task Force on Alternate Health Plans be continued for another year.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #4 AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Dr. Arnold Lempka, Omaha - Chairman
Dr. Stanley F. Nabity, Grand Island
Dr. R. R. Andersen, Nehawka

Reference Committee #5

Reference Committee #5 considered three reports and one resolution. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

The report of the Commission on Legislation and Legal Affairs was reviewed and testimony was heard from a number of participants. The activities of the Commission in sponsoring the legislator information and awareness day was particularly commended. It was also noted that the dinner hosted by the NMA physicians was very well received and was felt to be a success. It was called to the Committees attention that the individual physicians did pay for the dinner and that many of the legislators expressed their appreciation of the dinner. The Commission is complimented for its "reactive" stand in legislative affairs. It is felt that this should continue to be the posture of the society and legislative success will be the result. Particular appreciation was expressed to the Association staff and lobbyist for their close relationship with the Legislature and their very effective liaison. The third paragraph of the report should be updated to indicate that LB 407 has been passed with the emergency clause.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

The next item considered was the report of the Commission on Public Affairs. The report was reviewed and the concerns addressed in the report are felt to be timely. Continued emphasis on physician and public communication is needed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REPORT OF THE BOARD OF DIRECTORS — ITEM #11 — LONG RANGE PLANNING

The Long Range Planning Report was reviewed and testimony from Board members was heard. The goals and objectives are felt to be very appropriate and the organization to accomplish the goals was reviewed and should make the organization more functional and more effective. In b. Interprofessional Code of Ethics under Item #3 of Goals and Initiatives, the Committee suggests that the word "inner relationship" should be corrected to "inter relationships". Also the membership figures were reviewed and it was noted that very frequently the April membership is below the final year membership and the Committee hopes that this is the situation in 1985.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) RESOLUTION #6 — DODGE COUNTY — MALPRACTICE QUOTATION BY AMA OFFICIAL

The next item considered by our Committee was Resolution #6 from Dodge County regarding a quotation by Dr. James S. Todd quoted in newspaper items regarding the malpractice crisis. The resolution reads as follows:

> WHEREAS, a four-column article recently appeared in the Omaha World Herald titled, "Florida Malpractice Crisis Seen as Spreading", and
>
> WHEREAS, the article stated, in part, "while admitting that a **small percentage** of suits is due to incompetent or negligent practitioners, **doctors** tend to place most of the blame for the malpractice crisis on lawyers", and
>
> WHEREAS, the article stated, in part, "trial lawyers, on the other hand, contend that their targets are the 'bad' doctors who commit negligible acts", and
>
> WHEREAS, Dr. James S. Todd, **a top official on the AMA staff** was quoted as stating, "**the basis of the malpractice problem is malpractice**" and "ninety-five percent of claims dollars are for actions by doctors that are **indefensible**", and
>
> WHEREAS, member or non-member AMA physicians should be concerned about quotations of this derogatory nature from a top official of the AMA;
>
> THEREFORE, BE IT RESOLVED, that NMA national delegates to the AMA be instructed to investigate the validity of the above quotation by Dr. James S. Todd, and Further be it
>
> RESOLVED, that, if the above quotation from "a conference on professional liability held in San Francisco last year" be true, that the NMA delegates to the AMA be instructed to object to the derogatory quotation made by Dr. Todd, who because of his position with the AMA represents the practicing physicians of this state and this country.

The Committee was provided with a copy of a letter written by Dr. Todd on March 13, 1985, in reference to this quotation and it was felt that his letter satisfactorily explains the fact that he was grossly misquoted and his comments were taken out of context. This letter will be available for reference. In view of our review of his letter and the testimony presented at the Committee meeting, the recommendation of the Committee was that this resolution be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I WISH TO THANK DR. FORSMAN AND DR. VOIGTLANDER FOR THEIR WORK ON THIS COMMITTEE AND MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #5 AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Dr. Gordon Adams, Norfolk - Chairman
Dr. Richard O. Forsman, Omaha
Dr. George Voigtlander, Pawnee City

Reference Committee #6

Reference Committee #6 considered two reports, two resolutions and one list of requests. Reference Committee #6 submits the following report and recommendations.

(1) REPORT OF TASK FORCE, INTER-RELATIONSHIPS & INTERPROFESSIONAL COOPERATION

The Committee appreciates the thrust of the report which has been to create active discussion and to give us an update. Appreciation is extended to the Task Force for their continued efforts. We thank the Committee for their useful work and report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE AD-HOC COMMITTEE ON MATERNAL AND CHILD HEALTH

The Committee received the report of the above Committee on Maternal and Child Health and appreciates their work. This is a method of education for the purpose of evaluating and reviewing infant mortality statistics plus review through various obstetrical meetings as well as being printed in the Nebraska Medical Journal. This report is gratefully received and the Committee appreciates the good work and commends the Committee for its report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REQUESTS FOR LIFE MEMBERSHIP

The list for the request of Life Membership was reviewed and approved without reservation. We agree with the Board of Councilors that they be accepted. These requests are as follows:

ADAMS COUNTY MEDICAL SOCIETY
Clyde Kleager, M.D., Hastings
Clarence Weber, M.D., Hastings

BOX BUTTE MEDICAL SOCIETY
James F. Kennedy, M.D., Alliance

BUFFALO COUNTY MEDICAL SOCIETY
Robert E. Butler, M.D., Axtell
Dan Nye, M.D., Kearney

CASS COUNTY MEDICAL SOCIETY
R. F. Brendel, M.D., Plattsmouth

CHEYENNE-KIMBALL-DEUEL COUNTY SOCIETY
A. H. Shamberg, M.D., Kimball

LANCASTER COUNTY MEDICAL SOCIETY
R. G. Gelwick, M.D., Lincoln
R. A. Hillyer, M.D., Lincoln
G. Wm. LeWorthy, M.D., Lincoln
Guy Matson, M.D., Lincoln
Fred M. Nebe, M.D., Lincoln

METROPOLITAN OMAHA MEDICAL SOCIETY
Albert E. Freed, M.D., Omaha
Gordon E. Gibbs, M.D., Omaha
Thomas J. Gurnett, M.D., Omaha
J. M. Horwich, M.D., Omaha
James F. Kelly, Jr., M.D., Omaha
Stanley Lutz, M.D., Bellevue

SCOTTS BLUFF COUNTY MEDICAL SOCIETY
Stuart D. Campbell, M.D., Scottsbluff
Stuart P. Wiley, M.D., Gering

YORK COUNTY MEDICAL SOCIETY
W. E. Hieb, M.D., Henderson

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) RESOLUTION #2 — METRO OMAHA — LOW-LEVEL RADIOACTIVE WASTE DISPOSAL ACT OF 1980

The Committee heard this report and resolution which reads as follows:

WHEREAS, the low-level waste policy act of 1980 has established guidelines for the United States of America's disposition of low-level radioactive waste, and

WHEREAS, the American College of Nuclear Physicians and the Society of Nuclear Medicine have been primarily active in the formation of the compacts and siting of disposal areas following the passage of the Low-Level Waste Policy Act of 1980, and

WHEREAS, the State of Nebraska and other member states of the Central States Compact have acted prudently under the guidelines of the Low-Level Waste Policy Act of 1980 and have made progress in fulfilling the obligations of that Act, and

WHEREAS, several regions of our country have not acted prudently and their incomplete development puts the disposal of low-level radioactive act in jeopardy, and

WHEREAS, the medical and research application of radioisotopes have a profound effect on the health and well-being of our populus, and

WHEREAS, approximately 30% of all biomedical research is dependent on radio-active materials and approximately 95% of all prescription drugs in America are developed using radioactive tracer materials and greater than 50% of all people admitted to a hospital in the United States have tests performed utilizing radioactive materials, and

WHEREAS, the majority of patients treatments for cancer in this country today utilize radioactive devices;

BE IT RESOLVED, that the Nebraska Medical Association be on record to support a strong, comprehensive and fair national policy for the development of regional low-level radioactive waste management sites as envisioned in the low-level radioactive waste disposal act of 1980, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association inform its elected representatives to Congress to support, in like, the low-level radioactive waste disposal act of 1980.

The purpose of this resolution is to draw attention to the Nebraska Medical Association the information as to importance of radioactive substances and their disposal and the law that was passed in 1980. We support the policy as stated. The Committee discussed and accepted this resolution.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #3 — METRO OMAHA — AMA LEGAL ACTION

The resolution read as follows:

WHEREAS, it is possible that with their office and practice expenses continuing to rise and limited payment for Medicare services being made, some physicians will find it impossible to provide the level and kind of services needed by patients and will have to stop caring for Medicare patients, and

WHEREAS, wherever that happens, it will deprive certain Medicare patients to choose the physician they want, and

WHEREAS, it was basic to Medicare that every beneficiary was to have free choice among qualified physicians and that nothing in the law was to penalize them for their choice, and physicians are prohibited by the law from freely entering into contracts with patients as they have done before, whether such-contracts are real or implied;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association support the legal action initiated by the American Medical Association in September, 1984, in Federal District Court against Margaret Heckler, Secretary of HHS, and

BE IT FURTHER RESOLVED, that the American Medical Association be notified of this support of the Nebraska Medical Association

This resolution was discussed and the Committee recommends the following substitute resolution:

WHEREAS, it was basic to Medicare that every beneficiary was to have free choice among qualified physicians and that nothing in the law was to penalize them for their choice, and physicians are prohibited by the law from freely entering into contracts with patients as they have done before, whether such contracts are real or implied, and

WHEREAS, it will deprive certain Medicare patients to choose the physician they want;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association support the legal action initiated by the American Medical Association in September, 1984, in Federal District Court against Margaret Heckler, Secretary of HHS, and

BE IT FURTHER RESOLVED, that the American Medical Association be notified of this support of the Nebraska Medical Association.

The Committee had some discussion without much disagreement, but particularly it was limited to the opinions as to a statement that may not be well accepted as far as stating limiting payment as far as Medicare patients are concerned.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #6 AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Dr. Perry Williams, Omaha - Chairman
Dr. Robert Morgan, Alliance
Dr. Jon Hinrichs, Lincoln

There being no further business, the House was recessed until 4:00 p.m.

THIRD SESSION

The third session of the House of Delegates was held on Sunday, April 28, at the Cornhusker Hotel, Lincoln, Nebraska.

The meeting was called to order by the Speaker, Dr. McFadden. A call for a quorum showed 44 delegates present, and the House was declared in session.

Dr. McFadden called for approval of the minutes of the second session, and these were approved.

Oral remarks were presented to the House by Senator John DeCamp and Senator Dan Lynch.

Dr. McFadden called for the report of the Nominating Committee, and the following slate of officers was presented by Dr. Gary Smith, Chairman:
President-Elect — Hiram Walker, M.D., Kearney
Board of Directors, At-Large — Richard Raymond, M.D., O'Neill
Delegate to the AMA — Carl J. Cornelius, Jr., M.D., Sidney
Alternate Delegate to AMA — Louis J. Gogela, M.D., Lincoln
Councilors:
5th District — Wm. Chleborad, M.D., Fremont
6th District — Robt. Herpolsheimer, M.D., Staplehurst
7th District — Robt. Quick, M.D., Crete
8th District — Floyd Shiffermiller, M.D., Ainsworth
Council on Professional Ethics — L. D. Cherry, M.D., Lincoln

There were no nominations from the floor, and a unanimous ballot was cast for the slate of officers presented.

There being no further business, the meeting was adjourned.

WashingtoNotes

(Continued from page 12A)

tors reportedly have considered a 9% factor. As one possible alternative to the President's proposed freeze on payments for the direct costs of medical education, they have considered a plan advanced by Johns Hopkins University President Robert Heyssel, M.D., to limit Medicare funding for graduate training to some "finite period," such as three years.

The Heysell proposal has also caught the attention of Quayle and Waxman and been recognized by the Association of American Medical Colleges as one of several alternatives that might be pursued. The AAMC and other key players have been reluctant to recommend or endorse a particular solution, however, and the confusion and Congressional interest have spawned a multitude of studies and task forces. The AAMC, the AMA and the AHA have formed separate advisory committees on the subject and have held some joint meetings. Thus far, however, these meetings appear to have been more successful at delineating areas of difference than agreement.

In the face of such controversy, all the involved groups are urging the legislators not take what AMA representative Robert Stone, M.D., termed "precipitous action that could determine not only our graduate medical education system but the quality of our health system as a whole."

* * *

FTC Issue Appears to Fade

The AMA vs. FTC feud over regulations of professionals, once a subject of heated debate, has receded from prominance.

In 1982, it prompted congressional dispute and widespread media publicity; last month, it received only mild attention from committees in the House and Senate, a couple of newspaper reporters, and a handful of high school students on tours through Congress.

Two factors are credited with the change in mood; first, a recent Supreme Court ruling that clarified the role of state regulations in antitrust cases and, second improved communication between the AMA and the FTC over areas of professional self-regulation and discipline.

Because of these new developments, the AMA will no longer push for a professions provision spelling out FTC's authority. Neither will the American Bar Association press that earlier position.

"It is no longer necessary to adopt specific language concerning the professions," AMA president Joseph F. Boyle, M.D., told Sen. Robert W. Kasten Jr. (R-WI) of the Consumer Subcommittee of the Senate Committee on Commerce, Science and Transportation on hearings about FTC Reauthorization. "On the contrary, we feel that such language could be counterproductive as establishing rigid limits in a period of mutual discussion and evolving law."

The FTC, for its part, has become increasingly willing to recognize the role of self-regulation by physicians. The FTC has said it supports self-policing and discipline of physician by groups such as the AMA, but will continue to monitor professional conduct over anti-competitive practices, price fixing, fraud, deceptive advertising, and restraints on trade. Unlike the AMA, the FTC still seeks specific language that would spell out its authority over professionals.

The conciliation, if adopted by Congress, means that anti-trust disputes about state regulation of professionals will end up being resolved in court rather than being set by statute. This change is accepted by both the AMA and traditional adversaries such as Congress Watch.

In addition, the Supreme Court decision **Southern Motor Carriers** case provided importance guidance about the application of anti-trust laws to state-supervised activities.

The Supreme Court decision in the recent **Southern Motor Carriers** case was significant because it loosens conditions under which the professions are covered by state laws and thus protected from FTC intervention, according to AMA's testimony. In the past, the FTC would steer clear of anti-trust situations that were part of an active, "compulsive" state policy — for instance, situations in which a state forced professionals to set certain prices. The **Southern Motor Carriers** decision says that there doesn't have to be evidence that a state forced professions to set rates — only that the state allowed professions to set rates.

For instance, the decision may insulate doctors in the Maine Medical Society who meet with members of the state Medicaid board to discuss fee structure. Although the state does not require that these groups meet, it allows them to — and hence would protect them from FTC regulation.

In fact, the language of the professions amendment could actually be counterproductive, said Dr. Boyle, by inhibiting disciplinary actions by professional groups against negligent physicians. "State boards are able to identify negligent physicians and have the opportunity to exert discipline . . . But there is the perception that this would be interfered with by restrictive language."

The professions language is supported by the nurses and opticians employed by chain drug stores. Recent FTC actions — such as the "Eyeglasses I" and "Eyeglasses II" rules that removed restrictions on advertising and the release of prescription to a patient — have helped keep down costs, the opticians said. The position also is opposed, although for different reasons, by the dentists. The American Dental Association witness predicted that an "overzealous" FTC will see no limit on its authority over state laws; Congress should define the FTC's authority to invalidate state laws, he said.

* * *

Heart Transplants Under Consideration for Medicare

Heart transplantation is being rapidly transformed from an experimental to a therapeutic procedure, federal officials announced at a Washington recent press conference.

They stopped short of guaranteeing Medicare coverage for the procedure, however, saying it needed further study over the next several months.

The government's new review of heart transplantation was prompted by the optimistic results of a long-awaited study by the Battelle Research Center.

The $1.6 million study analyzed the cost and outcome of 441 heart transplant cases performed between 1975 and 1983 at six national transplant centers.

If the government decides to reimburse under Medicare, probably only 85 to 100 of the 42.7 million Americans with cardiovascular disease will be eligible for surgery each year. It is likely that selection criteria will be very stringent, limiting transplants to patients under age 55 and free of other medical problems. Because Medicare is restricted to persons over age 65 or disabled more than two years, few of these beneficiaries will qualify.

Thus, the pricetag may be relatively small. Battelle researchers estimated that the total cost of covering heart transplantation would range from $2 million to $3.5 million a year, much less than the $2 billion a year spent on the controversial End Stage Renal Disease Program (ESRD). Each heart transplant recipient would cost roughly $37,000, compared to the $30,000 spent on each of the 70,000 ESRD dialysis patients each year, but with only a few hundred patients qualifying, the total cost should be low.

The Battelle study found that roughly 80% recipients of heart transplants are alive after 1 year and 50% are alive after 5 years. One-quarter will survive longer than 10 years. An estimated 32% of transplant recipients have gone back to work and 67% consider themselves "in good health." The dramatic increase in survival rates for heart transplant recipients can be traced back to the introduction of cyclosporine in 1980.

Complications, when they appear, are generally linked to immunosuppressive therapy. Five complications are most common: osteoporosis (18.2%), diabetes (14.9%), vision disorders (14.3%), back or spine disorders (8.8%), and cancer (6.1%).

Selection criteria for patients were strict, thus excluding aged or sick patients who would have lowered survival statistics, the study found. The typical recipient was only 42 years old. The six centers accept only persons who are free of active infection, multiple organ dysfunction, illness or rehabilitative difficulties, pulmonary problems, or diabetes.

Funding is a major source of concern for heart transplant recipients. Although the majority of private insurers and 12 states pay for transplant procedures, roughly 70% of recipients paid for pre-transplant and post-transplant expenses out of their own pockets.

In many cases, recipients depended upon the transplant center or direct donations to help fund their procedure.

"It is still a technique to be applied only when a specific set of clinical criteria has been fulfilled," warned HHS Secretary Margaret Heckler. "Data suggest that the rate of success may be accomplished only in medical centers where a "critical mass" of clinical experience and expertise has been gathered."

"We would never take a position that would simply guarantee heart transplants to every American at government expense," she added. "We would oppose universal eligibility for government funding for heart transplants."

* * *

Supreme Court Agrees to Rule on Abortion . . . Again

The abortion issue will take on new prominence next fall as the Supreme Court justices review two controversial state abortion laws.

The two state laws — in Pennsylvania and Illinois — already have been declared unconstitutional by federal appeals courts. The laws would have given the state governments a major role in the abortion decisionmaking process by specifying how a doctor must perform some abortions and what he must tell his patients.

Court approval of the laws could give abortion opponents a green light to pass more restrictive state laws.

On the other hand, rejection of the laws would further protect a women's right to abortion and reduce the risk of later tampering by a Reagan-appointed member of the court.

The court's decision to review the laws puzzles both advocates and opponents of abortion. It is uncertain, they say, whether the court will try to expand or contract the power of states to regulate abortion.

The two cases to be argued in the next session are:

* an Illinois law that would have made it a crime for a doctor to cause the death of a viable fetus by performing an abortion. It also would have required that doctors inform their patients that some contraceptives — such as IUDs and morning-after pills — are "abortifacients" that cause fetal death by preventing the fertilized egg to reach the womb.

* a Pennsylvania law would have required that a doctor give a detailed description of the risks of abortion. In addition, it would have imposed a 24-hour waiting period and required that all second trimester abortions be performed in a hospital.

Similar state provisions were overturned two years ago in the Supreme Court's 6-to-3 decision in **City of Akron V. Akron Center for Reproductive Health.** This decision, which rejected the state's role in determining where, and how, an abortion is performed, was assumed to have firmly established a woman's right to the procedure.

* * *

NIH Says 'No' to Central Transplant Registry

A centralized national registry for bone marrow transplant donors should not be established at this time, a panel of National Institute of Health (NIH) transplant specialists has recommended.

Instead, the medical community should promote and expand the local registries that already exist, it said.

Only one-third of patients needing bone marrow transplants have an HLA-identical sibling donor. Since there is low probability of finding HLA matches in unrelated persons, registries seek large numbers of volunteers to serve as potential donors.

However, of the 70 patients transplanted with marrow from matched unrelated donors, only 20% have survived 3 months; one patient has survived 3½ years.

Merging local donor programs into a single national data base could in fact, be counterproductive, the panel said. Donation of bone marrow is highly dependent upon a spirit of voluntarism and altruism; local centers are effective because of the extent of local community involvement. A broad national program could be less effective, it believed.

* * *

Senate Panel Finds Pacemaker Problems Persist

Two years after a major shakeup in the pacemaker industry, significant problems persist, the Senate Special Committee on Aging has found.

Overutilization, defective devices, fraud and abuse continue to plague the pacemaker industry, its investigation revealed. In addition, the congressionally mandated National Pacemaker Registry — which would have monitored pacemaker performance and utilizaton — has not yet been established.

A 1982 Congressional hearing found that some pacemaker prices were marked up as much as 560%; physicians were charging up to $2,000 for implants; warranties were uncollected by Medicare; physicians were making unnecessary implantations; and payments were provided to physicians who implanted a certain brand of pacemaker.

Based on these findings, Congress attempted to tighten up the industry by enacting legislation that established the Registry, new guidelines for implantation monitoring, and other provisions.

Now, Congress says that the law has been neglected and the Pacemaker Registry has become a "hot potato" between the Food and Drug Administration and the Health Care Financing Administration.

The new investigation found:

* continued overutilization of pacemakers; as many as 30,000 of the estimated 110,000 original pacemaker implants may have been unnecessary, according to a General Accounting Office review included in the investigation. In addition, as many as 21,000 replacement implants may be unnecessary.

* kickbacks, fraud and abuse continue. There have been two criminal convictions since the 1982 hearing: Pacesetters Systems Inc. and Telectronics officials pleaded guilty to offering kickbacks to physicians who used their pacemakers. Additional FBI investigations are underway.

* delay in implementing the Registry. The deadline for the Registry to be in operation was January 1985. Now, FDA says the Registry will be operational by December 1987.

* * *

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Tobacco Industry Rebuked on Label Rotations

A tobacco industry proposal to run cigarette label warnings simultaneously, rather than rotating every three months, has been rejected by the Federal Trade Commission (FTC).

A bill passed by Congress last year specifically stated that cigarette packages would run four different warnings each year. Rotating warnings would have greater impact on smokers, Congress believed.

The quarterly printing of different warnings — in January, April, July and October— is too expensive, the tobacco companies said. It is estimated that the label change will cost a total of $12 million a year for tobacco firms.

The FTC does not have the discretion to change a statute passed by Congress, said spokeswoman Judy Pond. The FTC, however, plans to ask Congress to review the statute to see whether label modifications are acceptable.

* * *

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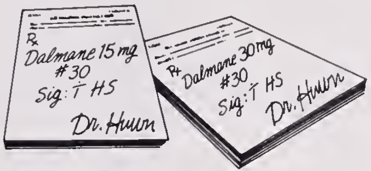

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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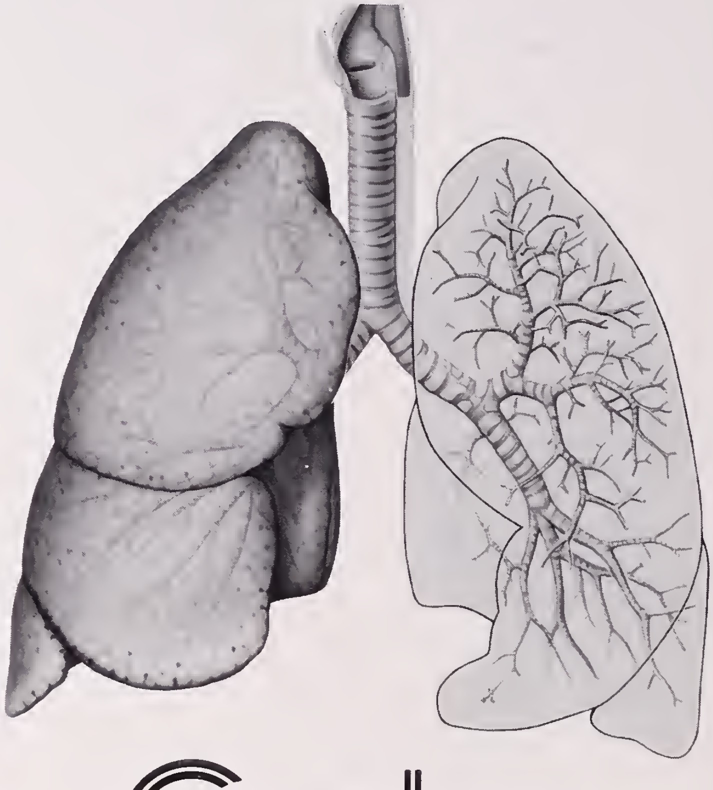
Consider the causative organisms...



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Brief Summary. **Consult the package literature for prescribing information**

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[0617B2R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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See following page for brief summary of prescribing information.

SORBITRATE™
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg) Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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Wilmington, DE 19897

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Alzheimer's Hearings Launched

"Like so many unfortunate victims of Alzheimer's disease, my father lost virtually all mental and neurological functions," Maria O'Brien recently told members of a House of Representatives subcommittee in May. O'Brien was speaking of Academy Award-winning actor Edmond O'Brien.

"Ironically, a man who once could hold an audience in the palm of his hand, towards the end had great difficulty expressing even his most basic feelings of affection, recognition and love," she said.

The burden of around-the-clock care and supervision rests squarely on the family, she said. Families suffer in silence, receiving little help. The prognosis is often poverty. Medicare does not cover the cost of caring for the

(Continued on page 12a)

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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
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80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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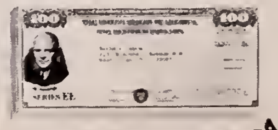

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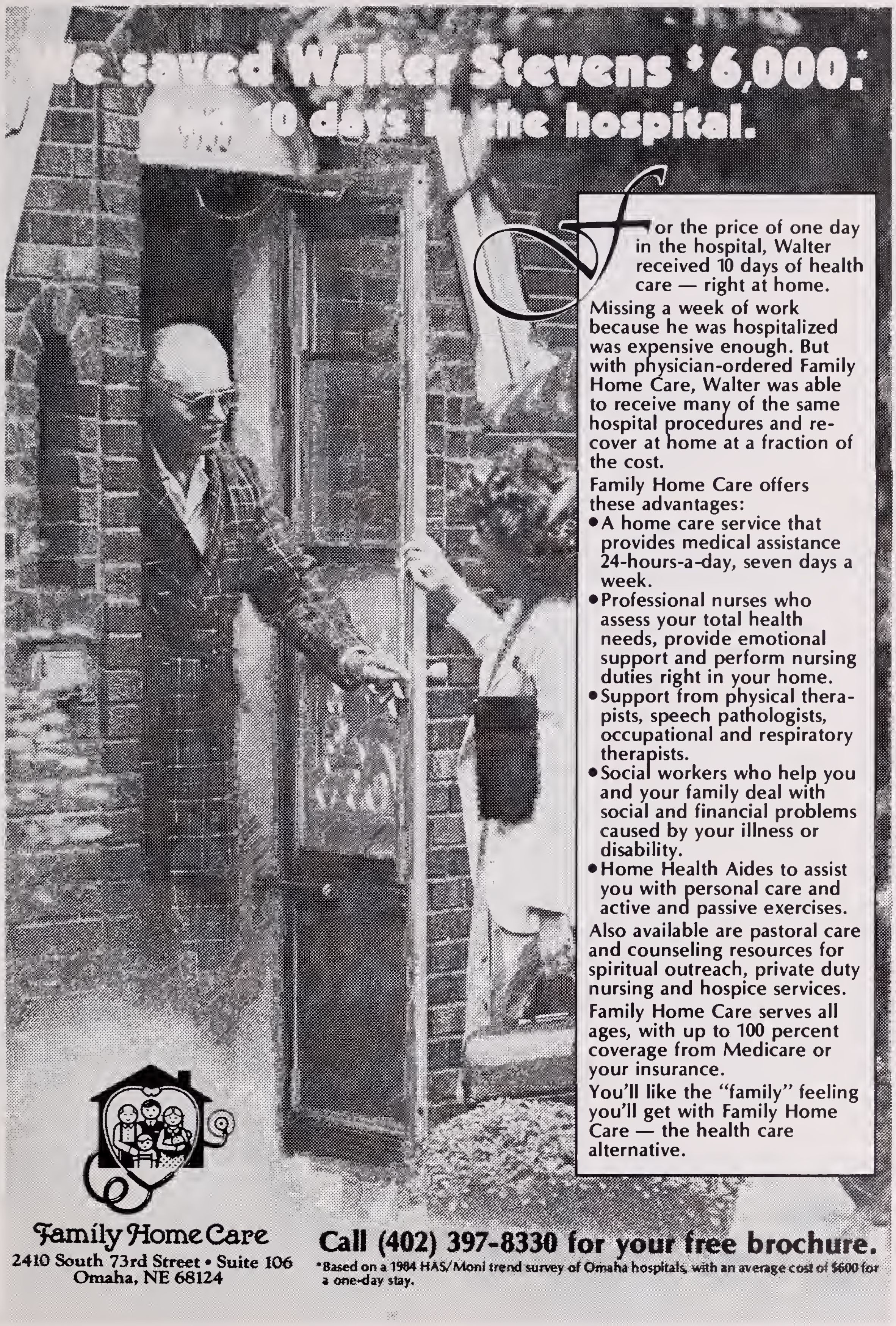

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WashingtoNotes

(Continued from page 6a)

Alzheimer's patient, either at home or in a nursing home. There is no insurance, no tax break, and very often no affordable in-home or day care programs capable of caring for Alzheimer's patients, added other witnesses testifying at the hearing.

Rep. Edward R. Roybal (D-CA), chairman of the House Select Committee on Aging, is proposing legislation that he believes would ease the burden of the disease on its victims and their families.

If passed, the Comprehensive Alzheimer's Assistance, Research and Education Act (CARE) of 1985 would:

—establish a national educational program,

—create model state programs to educate the public and offer support,

—expand federal research into the causes, prevention, and treatment,

(Continued on page 312)

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Immanuel Medical Center

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Spouses are invited to participate in special activities; participants and faculty will enjoy an evening of "dining out" together on Friday, Sept. 27. Participants are housed at the beautiful new Immanuel Plaza Motel on the Medical Center Campus.

An agenda for the two-day program is as follows:

First Day

Hypertensive Disease of Pregnancy
    Terrence J. Kolbeck, M.D.
Premature Rupture of the Fetal Membrane
    C.J. LaBenz, M.D.
Management of Premature Labor
    Carter Lomax, M.D.
Anticonvulsants in OB
    John C. Goldner, M.D.
Genetic Amniocentesis
    Warren G. Sanger, M.D.
Postpartum Hemorrhage
    Thomas E. Martin, M.D.
Treatment of Menopausal Symptoms
    Jeffrey B. Itkin, M.D.
The Management of Erythroblastosis Fetalis
    G. William Orr, M.D.
Herpes in OB
    Terrence J. Kolbeck, M.D.
    Peggy J. Rapoport, M.D.
    Joseph M. Rapoport, M.D.

Second Day

Management of Postdatism
    G. William Orr, M.D.
Diagnostic Imaging in OB/GYN
    Gordon F. Johnson, M.D.
Alphafetal Protein
    Mark Lubinsky, M.D.

For more information on this or future Fellowships, contact Marion Kaple, Holling Education Center, Immanuel Medical Center, 6901 North 72nd Street, Omaha, Nebraska 68122, (402) 572-2340.

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Spouses are invited to participate in special activities; participants and faculty will enjoy an evening of "dining out" together on Thursday, Oct. 3. Participants are housed at the Immanuel Plaza Motel on the Medical Center campus.

First Day

- Differential Diagnosis of Chest Pain
  - Richard E. Collins, M.D.
- Electrocardiography
  - Richard E. Collins, M.D.
- Treadmill Testing
  - Steven J. Diamantis, M.D.
- Current Therapy for Angina Pectoris
  - Michael M. Dehning, M.D.
- Percutaneous Transluminal Coronary Angioplasty
  - Richard E. Collins, M.D.
- Cholesterol and Coronary Artery Disease
  - Joseph M. Rapoport, M.D.
- Nutrition and the Heart Patient
  - Sue Fargher, R.D.
- Coronary Bypass Surgery
  - David A. Hughes, M.D.
- Current Methods of Myocardial Infarction Reduction
  - Steven J. Diamantis, M.D.
- After Infarct — What Next?
  - Michael M. Dehning, M.D.
- Case Studies
  - Richard E. Collins, M.D.
  - Michael M. Dehning, M.D.

Second Day

- Bedside Exam of Cardiac Patient
  - Richard E. Collins, M.D.
- Valvular Heart Disease
  - Richard E. Collins, M.D.
- Echocardiography
  - Michael M. Dehning, M.D.
- Current Therapy of Congestive Heart Failure
  - Steven J. Diamantis, M.D.
- Pre-op Evaluation of the Cardiac Patient
  - Michael M. Dehning, M.D.
- Stress Management
  - Richard E. Collins, M.D.
- Approach to Sudden Death
  - Steven J. Diamantis, M.D.
- Pacemakers
  - Michael M. Dehning, M.D.
- Current Therapy for Hypertension
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- Future Trends
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Thiazides may add to or potentiate the action of other antihypertensive drugs.

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THE NEBRASKA MEDICAL JOURNAL

Restructuring Control of the Health Care Industry

V. WILLIAM MEYERS, M.D.*
Medical Director
Bergan Mercy Hospital
Omaha, Nebraska

A CONTINUING plethora of information in the media and trade journals reflects the myriad of changes occurring in the health care delivery system. Dissecting the common thread of concern reveals that one dollar out of ten of the Gross National Product is too consuming and rewarding for health care.

In 1946, public policy stimulated the retrospective payment system with easy access to capital, encouraging the tremendous growth in the delivery system. Medicare, in 1965, created cost reimbursement for its population. Money flowed easily to providers for acquiring new technology, physical plants, and for multiplying programs and services. Consumers were insulated from financial risk; expensive environments were encouraged for delivery of care; and buyers and insurers of health care continued to expand benefits of health plans.

In 1982, the prospective financing of health care for Medicare was introduced with the Tax Equity and Fiscal Responsibility Act (TEFRA) and reinforced with Prospective Payment System (PPS) a year later. These legislative pieces produced a ripple effect through the private payer industry creating a need for similar financing to diminish the ability of cost shifting by providers. The domino effect has created a reshuffling of the pecking order of control and is resulting in a major restructuring of the health care industry. Thus, a new reality:

Old	**New**
Physicians	Consumers
Hospitals	Employers
Insurers	Government
Government	Insurers
Employers	Hospitals
Consumers	Physicians

The competitive model or prospective payment of health care — service for a defined price — has created an inversion of the participants with the consumers or their payer representatives in control by becoming shoppers for health care services. Trends are apparent. The control of the delivery of health care through organizations rather than independent providers is rapidly increasing. Equivalent quality of care can be delivered in less expensive environments is continuing the decline in most hospitals' census. The traditional established provider patient relationships are being fractured in multi-resourced environments through consumer orientation, education and payer designation. Unorganized providers, if their price is right, are buying back their traditional patient care base through contractual relationships with organized alternative delivery systems. Providers themselves are not organized in a competitive model, which allows those who are already in a weak position to be further compromised and dictated to by well organized systems. Independent non-profit hospitals, as well as physicians, can all be at significant risk for a patient care base without some collaborative organizational effort to challenge the equity market financing available to the for-profits and Health Maintenance Organizations (HMOs).

Without point by point discussion, Table I reflects how the new health care system is evolving, directed primarily by different financing and the impact of organizational market driven forces versus control by independent providers.

---

*Reprints: V. William Meyers, M.D., Medical Director, Bergan Mercy Hospital, 7500 Mercy Road, Omaha, Nebraska 68124.

TABLE I

RESTRUCTURING CONTROL OF THE HEALTH CARE SYSTEM

	OLD		NEW	
PHYSICIANS	Fee for service Retrospective payment Independent orientation		HMO Salaried IPA[1] Contractual Networks PPO[2] discount pricing J.V.[3] collaboration Group orientation	
HOSPITALS	Independent Non-profit For-profit	**Products** Primary care Secondary care Tertiary care One hospital, 3 levels of care[4]	For Profit › growth › medical education › high technology › physician office buy out Non-Profit › system networking	**Products** One hospital, 1 or 2 levels of care Preadmission screening Outpatient Surgery One Day Surgery Skilled Nursing Emergicenters Diagnostic center Home Health Care Hospice Day Care Center Health Insurance
INSURORS	Assumed risk-benefit plans Administrative services Indemnity insurance		Designing benefit plans Facilitators Negotiators Marketing Brokers for providers Claims processing	
GOVERNMENT	Cost reimbursement › Regulation ● PSRO[5] ● CON[6]		Prospective › TEFRA › PPS Capitation Voucher CMO[7] › Regulation ● PRO[8] ● Rate setting ● Competition - market controlling	
EMPLOYERS	Full health care benefits Quality of care		Buyers Self insured Claims processing Utilization Review Peer Review Health Promotion	
CONSUMERS	Minimal financial risk Freedom of choice		Deductible/co-payment Capitated Designated provider relationships	

[1] Independent Practice Association
[2] Preferred Provider Organization
[3] Joint Venture
[4] Due to the economies of scale for use of expensive resources, the traditional hospital will need to differentiate.
[5] Professional Standards Review Organization
[6] Certificate of Need
[7] Competitive Medccal Organization
[8] Professional Review Organization

In the competitive model, the organizational imperative, as opposed to individual imperative, is the strength for position and growth in the market. The power of organizations has been well demonstrated. They have moved into communities and within a short period of time, have physicians' patients and hospitals under their control. Independent providers negotiate risk contracts from a compromised position to regain or maintain their patient care base. Their organizational flagship needs support through establishing entreprenurial tentacles creating network units extending into other communities. This model then replicates itself into other regions. A growth company results with dividends that equity markets enjoy and which become attractive for more venture capital.

Competitive organizations are foreign to most physicians, and non-profit and community hospitals whose organization reflects only parochial, political and educational activity. The traditional financial dividends of their labors have historically been invested in capital improvements, additions to programs, and services for health care in the communities in which they serve.

The continuing growing strength of organizational American to deliver health care services is derived from known attributes of the industrial competitive model. Only when physician and non-profit hospitals remove the cloak of the cottage industry for their understanding of the power of the tools of the competitive model, namely the organizatonal imperative, financing and tax laws, will they be able to reshuffle the inversion and regain their traditional decision role, instead of an allocation role, as the advocate for patient care.

ORIGINAL ARTICLES

Pulmonary Infarct Incorrectly Diagnosed as Lung Cancer

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PULMONARY embolus is one of the most commonly misdiagnosed disease entities reported in the medical literature.[1, 2] Adding to the confusion is the fact that on occasion, pulmonary infarcts have been shown to give rise to atypical and even malignant appearing histology.[3, 4] We present a case of pulmonary infarction initially diagnosed as a malignancy which subsequently underwent lobectomy.

Case Report

A 74-year-old nonsmoking male, was admitted for evaluation of a left upper lobe mass and pleural effusion (Figures 1, 2). His chief complaint was hemoptysis for two weeks with a 10 lb. weight loss and anorexia over the preceeding months.

Physical exam was compatible with left pleural effusion. Thoracentesis and pleural biopsy were performed and were negative for malignancy. Bronchoscopy disclosed signs of acute and chronic bronchitis without any endobronchial lesion. Transbronchial biopsy of the lingula was negative for malignancy.

Percutaneous fine needle biopsy of the left lung mass was performed which yielded large pleomorphic cells mixed with the many benign histiocytes and multi-nucleated cells which were highly suspicious of malignancy (Figure 3). A thoracotomy was performed and a mass lesion in the anterior portion of the left upper lobe was present. Frozen section indicated poorly differentiated carcinoma and a lobectomy was performed. Histology confirmed the presence of an organizing embolus with an area of infarction. No evidence for carcinoma was found but pleomorphic cells resembling those found on fine needle biopsy were present (Figure 4). Recovery was uneventful.

Discussion

Cytologic examination is an important screening and diagnostic tool in the diagnosis of lung cancer with sensitivity and specificity of above 90% with a small percentage of false-positive diagnoses (less than 5%).[6]

The cytologic changes in pulmonary embolism with infarction consist of three dimensional papillary clusters of reactive bronchoalveolar cells presumably originating in the reparative epithelium of the alveoli and terminal bronchioles adjacent to the ischemic area.[5, 7] These cells are atypical enough in appearance to suggest malignancy and in a few cases resulted in the actual diagnosis of a neoplasm.[3, 4, 5 7] These changes are usually transient developing in the first week post-infarct with resolution by the third to fourth week.[7] The actual incidence of such exfoliation is unknown and low in view of high frequency of occurrence of pulmonary embolism in hospitalized patients, although one does not usually obtain sputum cytology when pulmonary embolism is suggested. As with our case, the dilemma begins when the clinical presentation is nonspecific and the diagnosis of pulmonary embolism is not even considered. This is further complicated by the appearance of a "mass lesion" on chest x-ray. A ventilation-perfusion lung scan will be difficult to interpret in the presence of an abnormal chest x-ray unless multiple defects are present; pulmonary angiography done later than 72 hours postembolism may be negative.[8]

Although, we suspect that many such patients who present in this fashion will eventually undergo a thoracotomy, a high index of suspicion and caution should be

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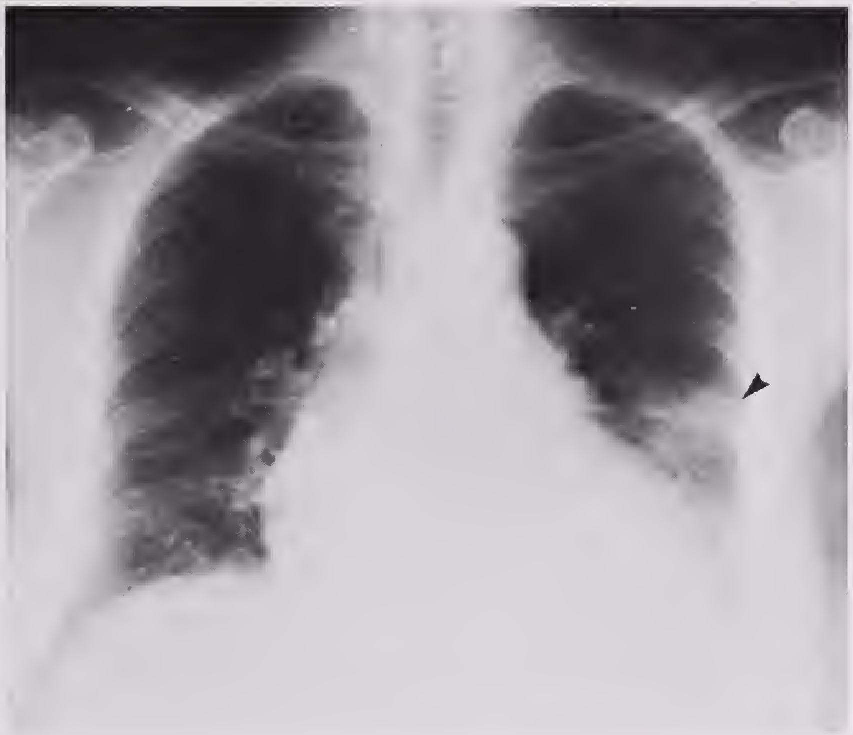

Figure 1

Admitting chest x-ray revealing circumscribed infiltrate (arrow) in left midlung field.

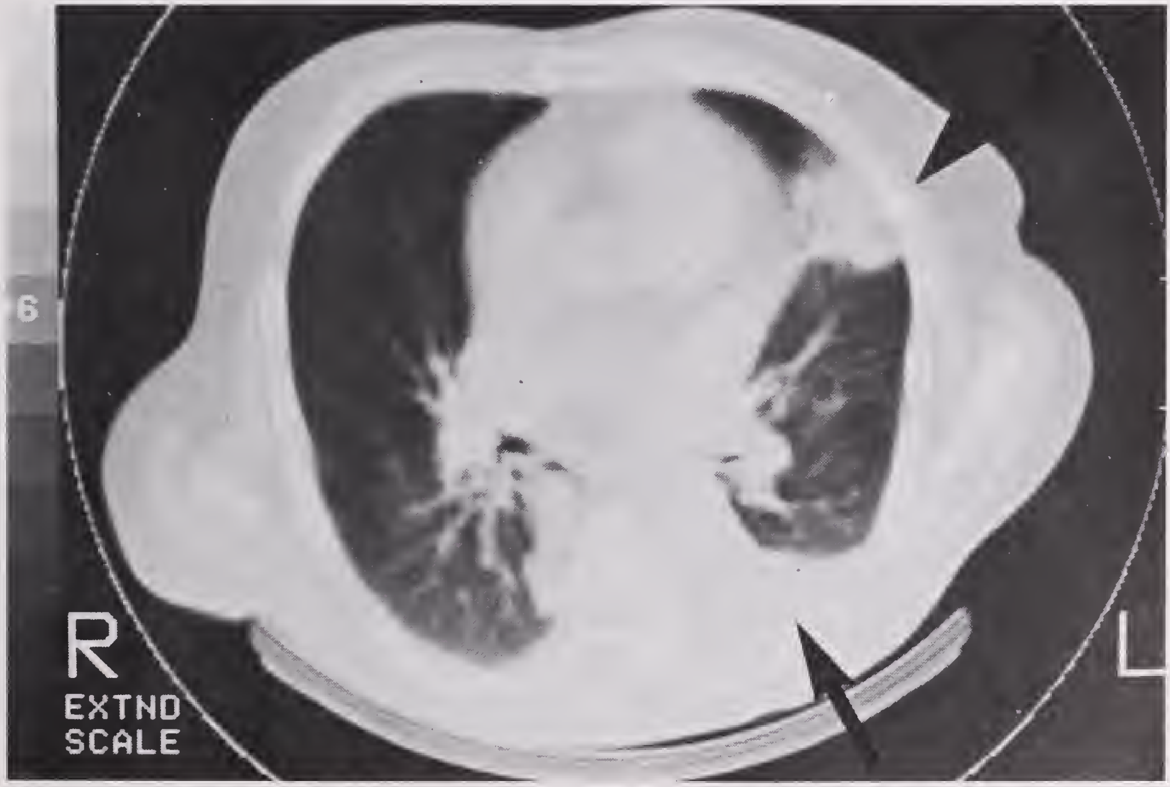

Figure 2

Computerized axial tomography revealing a masslike density (short arrow) in the left upper lobe and a left pleural effusion (long arrow).

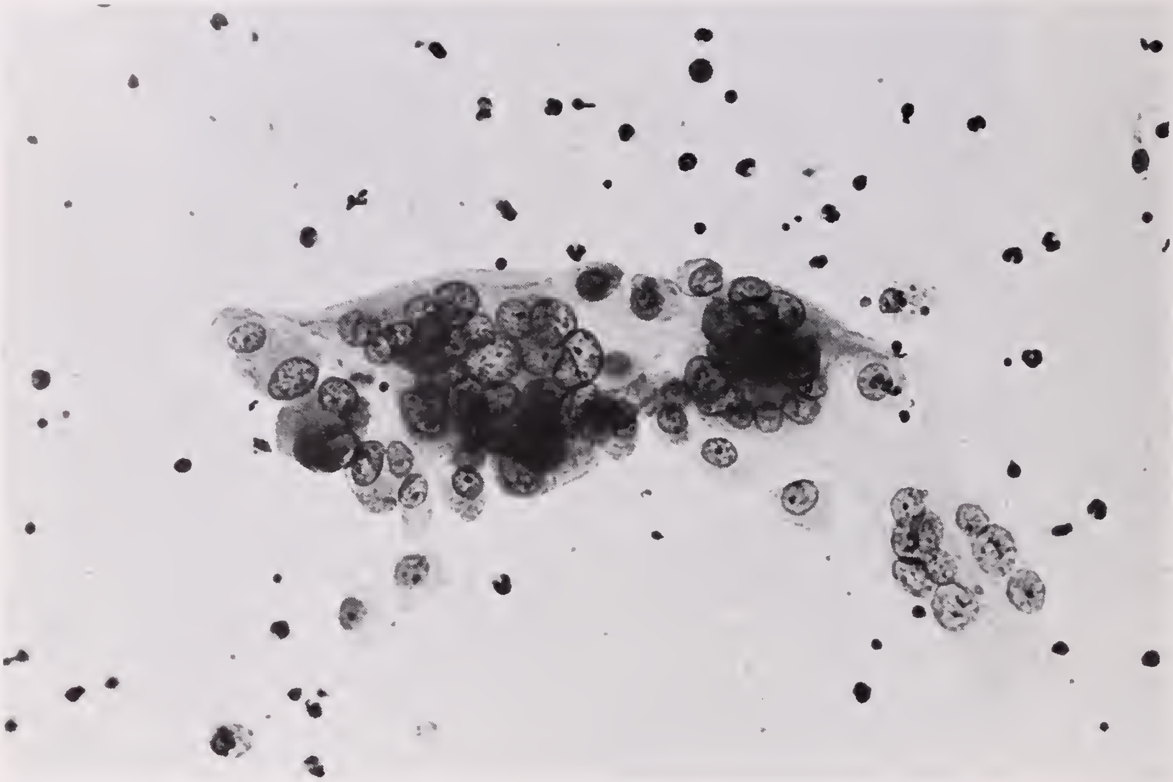

Figure 3

Fine needle aspiration cytology of left lung. Note acinar-like arrangement of cells, nuclei of variable size with irregular chromatin clumps and prominent nucleoli (Papanicolaou stain, x400).

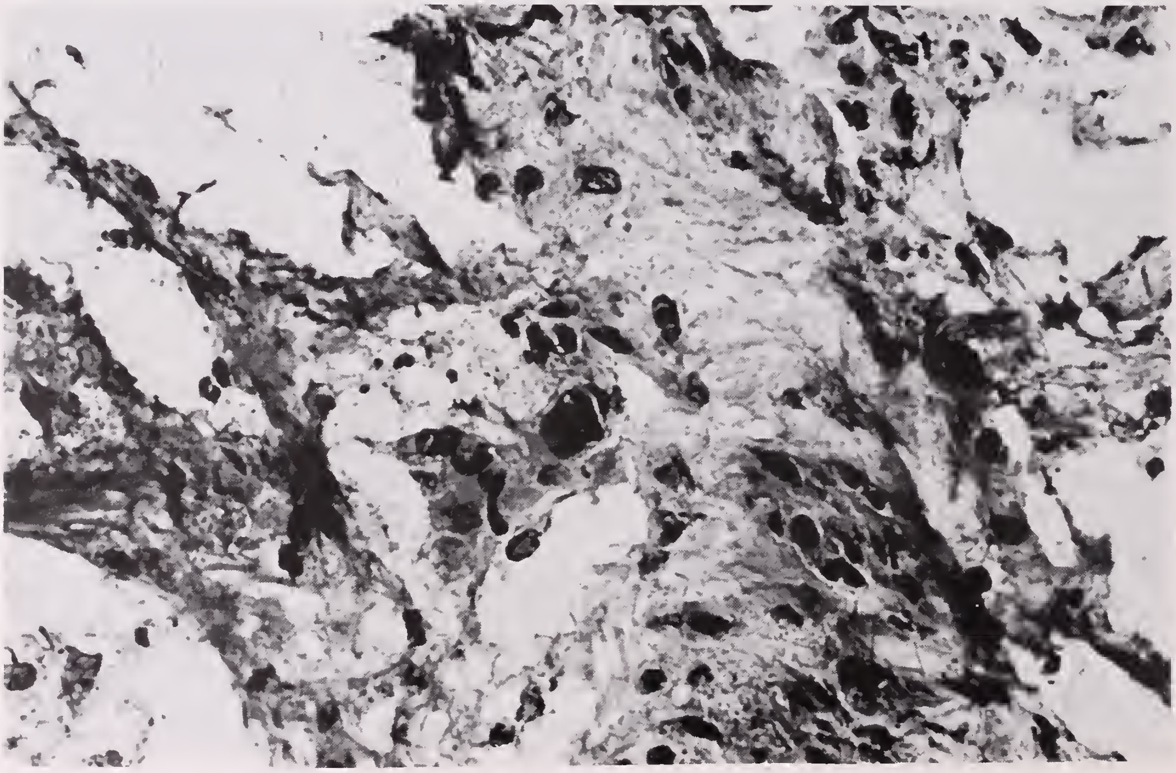

Figure 4

Higher magnification of reactive fibroblasts and atypical alveolar cells from periphery of infarct. Note cluster of atypical alveolar lining cells in center with large, pleomorphic, hyperchromatic nuclei (hematoxylin and eosin, x625).

maintained especially when pulmonary embolism is a consideration. Depending on the risk of malignancy and the patient's operative risk, repeat cytology in several weeks may be a reasonable alternative.

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Sexual Orientation and Sexually Transmitted Disease

Synopsis-Abstract:

4,340 adults randomly drawn from five metropolitan areas were questionnaired about their sexual orientation, involvement with unusual sexual practices (e.g., sadomasochism, bondage & discipline), oral/anal sex, number of homo- and heterosexual partners, and sexually transmitted disease (STD) experience. Bi-/homosexuals of both genders (4.4% of the sample) reported higher lifetime rates for most of the STDs and admitted to higher rates of deliberate infection of others than their heterosexual counterparts. Stepwise regression analysis indicated that degree of participation in unusual sexual practices, anal/oral contact, age and number of homosexual partners predicted STD experience. Younger adults and homosexuals more frequently reported engaging in both unusual sexual activities, oral/anal contact, and having had STD experience. Homosexuals appear to contribute no less than 15% of the nation's STDs and probably act as a significant vector in generating additional fractions to the STD pool.

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HOMOSEXUAL males suffer high rates of sexually transmitted disease; this has been known for some time. But how much higher and for which diseases? Further, little is known about sexually transmitted diseases (STDs) among female homosexuals.[1] Some have suggested that homosexual men probably have higher prevalence rates for gonorrhea, syphilis and anal warts, but lower rates for genital warts, lice and scabies than heterosexuals.[2] But basing such estimates upon volunteer subjects[3] or those who come to STD or VD clinics, introduces an unacceptable degree of uncertainty into estimations. Two recent studies have generated estimates that about 96% of the general population is heterosexual and the remainder bi- or homosexual,[4,5] but neither investigated STDs by sexual orientation. What is the incidence of hetero- and homosexual orientations, and how do they compare in STD rates?

Subjects and Methods

From February to November 1983 conventional one-wave systematic area cluster sampling was carried out in the Los Angeles, Denver, Omaha, Louisville, and District of Columbia (standard metropolitan areas) in addition to two small pilots in Bennett, NE and Rochester, NY. In Los Angeles, Denver, and the District of Columbia, sampling was carried out every day of the week from 9 A.M. to approximately 9:30 P.M.; in the other locations, sampling took place in late afternoons, early evenings and on weekends. The first adult answering the door was informed that our purpose was to conduct a random nationwide sexuality survey. If an eligible male were present, his cooperation was sought, but any one adult (aged 18 or older) from a household unit was solicited. Respondents were assured anonymity and asked to complete a 550-item questionnaire (which took about 75 minutes), seal it in the provided envelope, and then give it to the returning interviewer. Some retrievals were made as long as a week later. All non-retrievals were counted as rejections.

For varying reasons, some respondents preferred to mail in the questionnaire and they were given a stamped, self-addressed envelope for that purpose. Not-at-homes totalled 1911 in Omaha, 2720 in Los Angeles, 1774 in Denver, 1837 in D.C., 992 in Louisville, 24 in Bennett and 31 in Rochester. Rejections were 737 in Omaha, 855 in Los Angeles, 538 in Denver, 259 in D.C., 936 in Louisville, 26 in Bennett, 12 in Rochester. Mail-ins distributed were, respectively, 496, 834, 364, 539, 10, none, and 4. Mailed-in, respectively were 979, 934, 970, 635, 767, 43 and 12. Overall compliance rates were 44%, 36%, 52%, 44%, 45%, 62%, and 31%, respectively. The overall rejection rate was 36%, but since 63.3% of the potential mail-ins did not return the questionnaire, our overall compliance rate was 43.5%. Interviewers estimated the age and recorded the gender of those who rejected our efforts. The median age of rejectors was 55; 41.7% were male. Our sample was younger, more highly educated (34% of the men and 28% of the women reported a B.A.) and disproportionately white (91%; 3.5% Black, 2.3% Hispanic) compared to the general population. The pattern of results from each location was not statistically significantly different as a function of mailed-in vs. in-hand. A total of 4,340 questionnaires were obtained, 37% from men. The proportion of mail-ins designating themselves as bi- or homosexual did not vary more than 0.5% from the in-hands' proportion at each location. Overall, locations did not statistically significantly differ (as indexed by chi-square at the .01 level) in proportions claiming hetero-, bi- or homosexuality by gender. Ninety-five percent of the questionnaires returned by males and 93.5% of those returned by females were complete enough for meaningful analysis. The questionnaire was too extensive to reproduce here; the items relevant to this report were:

How many different homosexual sexual partners have you had in your lifetime? How many different heterosexual sexual partners have you had in your lifetime? I am a heterosexual/ bisexual/ homosexual. How often have your sexual experiences included (each of the following was accompanied by a 4-point scale--never/ once/ 2 to 4 times/ more than 4 times): sadomasochism, bondage & discipline, hand-balling (insertion of fist into rectum), urination, defecation (scat), enemas, sex with animals, threesomes/ orgies or group sex, masturbation during a phone call, paying for sex, being paid for sex, having sex in a gay bath, having sex in front of others, having sex in public, having sex in a peep show or booth, having sex in a public restroom (collectively counted as "unusual behavior")? How often have you had the following venereal diseases (VD) or sex-related maladies? (each of the following was accompanied by the same 4-point scale utilized in the preceding question): (1) syphilis, (2) gonorrhea, (3) genital warts, (4) hepatitis, (5) non-specific urethritis, (6) lice (crabs), (7) scabies, (8) vaginal/penile infection from vaginal contact, (9) vaginal/ penile infection from penile contact, (10) oral infection from vaginal contact, (11) oral infection from penile contact? Additionally, have you ever had any of the following (each answered "yes" or "no"): (12) rash in groin area, (13) sores on your genitals, (14) pain or bleeding from rectum not related to hemorrhoids, (15) penile or vaginal discharge for which no cause could be found? When you knew that you had a contagious disease, how often have you had sex to infect others? About how many people have you managed to infect with such a disease? How often has someone licked or tongued your anus (you had oral/anal sex)?

Results

Sexual Orientation

For the sample as a whole, 94.2% of the males designated themselves as heterosexual (mean age = 38.8; range age from 18 to 86; median of 34), and 5.8% bi- or homosexual (mean age = 35.2; age range from 18 to 79; median of 32); 96.9% of the females designated themselves as heterosexual (mean age 37.7; age range from 18 to 87; median of 33), and 3.1% as bi- or homosexual (mean age = 31.5; age range from 19 to 64; median of 29).

Sexually Transmitted Disease

Responses regarding lifetime experience for each disease are summarized by gender and sexual orientation in Table 1. The proportion of heterosexuals claiming disease experience for each disease was compared with the proportion of bi-/homosexuals' claims utilizing chi-square with $P<.05$. Males who claimed bi-/homosexual orientation reported higher incidences of syphilis, gonorrhea, genital warts, hepatitis, lice, scabies, infection from penile contact, oral infection from penile contact, genital rash and rectal pain. 50.9% of heterosexual males vs. 22.2% of homosexual men reported no such disease. Females who categorized themselves as bi- or homosexual reported higher rates of syphilis, genital warts, scabies, infection from vaginal contact, oral infection from vaginal contact, oral infection

TABLE 1

Sexual Orientation and Sexually Transmitted Disease by Gender

MALE

	heterosexuals				homosexuals			
disease/ condition	n	# ever had disease/ condition (% of ever)	# disease episodes (estimated* share of episodes in cohort) (A)		n	# ever had disease/ condition (% of ever)	# disease episodes (estimated* share of episodes in cohort) (B)	proportion of gender episodes attributable to bi-/homosexuals (B/A + B)
syphilis	1311	18(1.4%)	29(44.3%)		83	16(19.3%)	20(30.5%)	40.8%
gonorrhea	1347	139(10.4%)	184(61.0%)		83	29(34.9%)	50(16.5%)	21.3%
genital warts	1312	57(4.3%)	69(42.8%)		81	12(14.8%)	16(9.9%)	18.8%
hepatitis	1297	34(2.6%)	36(37.1%)		78	16(20.5%)	17(18.1%)	32.8%
NSU	1296	100(7.7%)	150(48.3%)	P<.08	79	11(13.4%)	16(5.1%)	9.6%
lice	1343	295(22.0%)	381(55.2%)		84	53(63.1%)	88(12.8%)	18.9%
scabies	1286	38(3.0%)	40(45.4%)		76	11(14.5%)	11(12.4%)	21.5%
infection from vagina	1301	95(7.3%)	143(67.8%)	P<.60	79	4(5.1%)	10(4.7%)	6.5%
infection from penis	1268	2(.2%)	3(.8%)		79	5(5.9%)	6(1.7%)	68.0%
oral infection from vagina	1297	9(.7%)	11(66.7%)	P<.99	78	—	—	0.0%
oral infection from penis	1278	—	—		80	8(5.9%)	10(24.0%)	100.0%
none of 11 STDS above	1216	851(70.0%)			73	24(32.4%)		
one of 11 STDS above		198(16.3%)				13(17.8%)		
two or more of 11 STDs above		167(13.7%)				36(49.3%)		
rash	1401	377(26.9%)	(70.0%)		89	34(38.2%)	(6.3%)	8.3%
sores on genitals	1382	111(8.0%)	(46.1%)	P<.21	88	11(12.5%)	(4.6%)	9.1%
rectal pain	1380	47(3.4%)	(33.2%)		88	19(21.6%)	(13.4%)	28.8%
genital discharge	1359	42(3.1%)	(24.3%)	P<.63	86	4(4.7%)	(2.3%)	42.6%
none of the 15 STDs above	1169	595(50.9%)			72	16(22.2%)		
one of the 15 STDs above		323(21.5%)				12(16.7%)		
two or more of the 15 STDs above		251(21.5%)				44(61.1%)		
had sex to infect others	1340	20(1.5%)	25(41.2%)		89	4(4.5%)	6(6.6%)	13.8%
# others managed to infect		29(2.1%)	64(39.6%)	P<.12		5(5.6%)	8(4.9%)	11.0%
FEMALE								
syphilis	2223	13(.6%)	15(15.7%)		63	8(11.3%)	9(9.5%)	37.7%
gonorrhea	2246	80(3.6%)	91(20.8%)	P<.07	70	6(8.6%)	7(1.6%)	7.1%
genital warts	2239	93(4.2%)	104(44.3%)		69	7(10.1%)	7(3.0%)	6.3%
hepatitis	2222	54(2.4%)	62(44.0%)	P<.91	69	1(1.4%)	1(.7%)	1.6%
NSU	2218	105(4.7%)	205(45.4%)	P<.78	69	3(4.3%)	5(1.1%)	2.4%
lice	2255	274(12.2%)	306(30.5%)	P<.16	70	13(18.6%)	15(1.5%)	4.7%
scabies	2202	43(2.0%)	49(38.2%)		65	5(7.7%)	5(3.9%)	9.3%
infection from vagina	2175	35(1.6%)	64(20.9%)		71	8(11.3%)	20(6.5%)	23.7%
infection from penis	2229	264(11.8%)	476(91.3%)	P<.07	71	14(19.7%)	32(6.1%)	6.3%
oral infection from vagina	2194	4(.2%)	4(16.7%)		69	4(5.8%)	4(16.7%)	50.0%
oral infection from penis	2208	16(.7%)	35(57.8%)		70	6(8.6%)	11(18.1%)	23.8%
none of 11 STDs above	2092	1601(76.4%)			64	44(68.8%)		
one of 11 STDs above		259(12.4%)				7(10.9%)		
two or more of 11 STDs above		235(11.2%)				13(20.3%)		
rash	2284	172(7.5%)	(22.0%)		73	13(17.8%)	(1.7%)	7.2%
sores on genitals	2273	162(7.1%)	(46.3%)		74	11(14.9%)	(3.1%)	6.3%
rectal pain	2295	104(4.5%)	(50.5%)	P<.24	73	6(8.2%)	(2.9%)	5.4%
genital discharge	2010	167(7.3%)	(66.6%)		74	17(23.0%)	(6.8%)	9.3%
none of the 15 STDs above	2010	1356(67.5%)			61	35(49.3%)		
one of the 15 STDs above		318(15.8%)				8(11.3%)		
two or more of the 15 STDs above		336(16.7%)				18(29.5%)		
had sex to infect others	2197	29(1.3%)	36(40.8%)		71	5(7.0%)	10(11.3%)	21.7%
# others managed to infect		45(2.1%)	71(30.1%)			5(7.0%)	52(25.4%)	45.8%

Note: All differences between hetero- and homosexuals for each gender for each disease category or event were tested with chi square and were statistically significant at or beyond the .05 level unless indicated otherwise.

*Male reports of disease episodes were multiplied by 1.24; female reports by .85

from penile contact, genital sores, and genital discharge. 67.5% of the heterosexual women vs. 49.3% of the homosexual women reported none of the 15 STDs.

In order to generate estimates of proportionate contribution to total cohort STD experience, male reports of disease episodes were multiplied by 1.24 and female results by .85 to bring the samples into conformity with population gender parameters. Column A (Table 1) for heterosexual males, column B for homosexual males, column A for heterosexual females and column B for homosexual females sum to 100% for each disease or event experience of that kind. Thus, for syphilis, the first row of Table 1 indicates that 74.8% (i.e., 44.3% + 30.5%) of all syphilis experienced by the cohort was reported by males (claims of 2 to 4 were counted as 2, and more than 4 as 5). Homosexuals accounted for a disproportionate amount of cohort infection for each STD (i.e., 40% of syphilis, 18.1% of gonorrhea, 12.9% of genital warts, 18.8% of hepatitis, 6.2% of NSU, 14.3% of lice, 16.3% of scabies, 11.2% of infection from vaginal contact, 7.8% of infection from penile contact, 16.7% of oral infection from vaginal contact, and 42.1% of oral infection from penile contact); and they also more frequently reported that they had engaged in sexual activity to infect others (i.e., 17.9% of deliberate and 30.3% of 'incidental' infection). Both homosexual men and women more frequently claimed to have indulged in oral/anal and 'unusual sexual practices' than their heterosexual counterparts (Table 2).

A stepwise regression analysis, in which the sum of "unusual sexual practices", the sum of the 11 STDs, and the sum of the 15 STDs were treated as scales, was performed. Results are summarized in Table 3. For both heterosexuals and homosexuals, degree of engaging in unusual sexual practices was the most predictive of STD experience, followed by participation in oral/anal contact. Younger members of the present heterosexual cohort reported proportionately more STDs, more anal/oral contact, and more participation in unusual sexual practices. Female homosexuals less frequently reported STDs than male homosexuals. For both homosexuals and heterosexuals, lifetime contact with number of homosexual partners was positively associated with STD experiences.

The 7% of male heterosexuals who admitted to at least one homosexual partner accounted for 14.5% of the male heterosexual set of 11 STDs and 13% of the 15 STDs. They also accounted for 15% of those who claimed to have deliberately infected others (and claimed to have caused 19% of the infections), 17% of those who admitted to oral/anal contact, and 11.4% of those who said that they engaged in strange sexual practices. The 3.1% of female heterosexuals who claimed at least one homosexual partner accounted for 6.1% and 5.7% of the sets of female heterosexual STDs. They also accounted for 6.9% of those heterosexual women who claimed to have deliberately infected others, causing 7% of the infections, accounted for 5.6% of those who indulged in

TABLE 2

Sexual Practices As A Function of Gender and Sexual Orientation

	male				female			
	heterosexuals		bi/homosexuals		heterosexuals		bi/homosexuals	
	n	# reporting (%)	n	# reporting (%)	n	# reporting (%)	n	# reporting (%)
unusual sexual practices	1260		78		2174		61	
none		535(42.5%)		10(12.8%)		1647(75.8%)		23(37.7%)
one		124(9.8%)		2(2.6%)		137(6.3%)		4(6.6%)
25 or more		93(7.4%)		47(60.3%)		44(2.0%)		12(19.7%)
			[$\underline{X}^2 = 302$; $\underline{P} < .001$]				[$\underline{X}^2 = 123$; $\underline{P} < .001$]	
participant in anal/oral sex	1259		80		2079		61	
never		938(74.5%)		17(21.3%)		1433(68.9%)		22(36.1%)
once		72(5.7%)		6(7.5%)		128(6.2%)		6(9.8%)
over 100 times		7(.6%)		16(20.0%)		48(2.8%)		5(8.2%)
			[$\underline{X}^2 = 237$; $\underline{P} < .001$]				[$\underline{X}^2 = 33$; $\underline{P} < .001$]	

Note: Scores for each unusual sexual practice could range from 0 to 3, the highest possible score was 48

TABLE 3

Predicting STDs: Stepwise Regression by Sexual Orientation

eleven STDs heterosexuals		eleven STDs bi-/homosexuals		fifteen STDs heterosexuals		fifteen STDs bi-/homosexuals	
unusual sexual practices	R=.334	unusual sexual practices	R=.687	unusual sexual practices	R=.313	unusual sexual practices	R=.652
oral/anal contact	R=.353	age	R=.721	oral/anal contact	R=.338	age	R=.691
age	R=.358	gender	R=.745	# homosexual partners	R=.341	oral/anal contact	R=.710
	R^2=.127	# homosexual partners	R=.782		R^2=.116	gender	R=.726
			R^2=.612			# homosexual partners	R=.738
							R^2=.545

	eleven STDs	fifteen STDs	age (s.e.)	gender (s.e.)	oral/anal (s.e.)	unusual sex (s.e.)	# homo partners (s.e.)	R^2
heterosexuals	dependent				.124 (.021)	.077 (.007)	.0008 (.0004)	.127
homosexuals	dependent		.034 (.013)	-.702 (.31)	.303 (.123)	.098 (.022)	-.0002 (.0001)	.612
	heterosexuals	dependent	-.004 (.001)		.129 (.026)	.107 (.0008)		.116
	homosexuals	dependent	.031 (.012)	-.88 (.295)	.324 (.116)	.107 (.021)	-.0003 (.0001)	.545

correlation coefficients

	11 STDs	15 STDs	oral/anal	unusual sexual practices	# homosexual partners	# heterosexual partners		11 STDs	15 STDs	oral/anal	unusual sexual practices	# homosexual partners	# heterosexual partners
male heterosexuals							male homosexuals						
age			-.18	-.12									
11 STDs		.88	.25	.41	.18				.94	.42	.47		
15 STDs			.22	.41	.14					.47	.59		
oral/anal contacts				.47	.14	.07					.55	.28	
unusual sexual practices					.29	.08							
female heterosexuals							female homosexuals						
age	-.13	-.15	-.23	-.19		-.07							
11 STDs		.90	.20	.26	.07	.18			.96	.34	.33	.34	
15 STDs			.21	.26	.08	.18				.32	.38	.32	
oral/anal contacts				.30	.11	.16					.54		
unusual sexual practices					.21	.17							.29
# homosexual partners						.07							

Note: All relationships statistically significant at or beyond the .01 level
s.e.: standard error

oral/anal practices, and 8.2% of those who claimed strange sexual practices.

Discussion

Incidence of the Various Sexual Orientations

The only reports of reasonably randomly obtained, non-volunteer samples yielded estimates that about 96% of the general population is heterosexual. Area cluster samples of 2,251 persons from six different areas of the country in which respondents were asked to designate self as heterosexual/mainly heterosexual/bisexual/mainly homosexual/homosexual reported that 96% of both genders chose the first two responses.[4] 477 residents of the San Francisco area, drawn via a random sampling technique,[5] judged the sexual preferences of their 831 siblings: 90% of the siblings were judged exclusively heterosexual, 6% mainly heterosexual with a small degree of homosexuality, 2% mainly heterosexual with a substantial degree of homosexuality, 1% bisexual and the remainder as mainly-to-exclusively homosexual. The rejection rates for the Kinsey Institute study[5] were not reported, but the six area investigation reported a compliance rate of 75%, significantly better than the present investigation probably due to its not being framed as a 'sexuality study'. While the metrics and questions employed in the two studies were not the same, it is salutory that responses regarding sexual orientation from 7 different areas of the U.S. utilizing direct[4] and indirect[5] measures, by teams locating at different ends of the homophile continuum, should generate almost identical estimates: that about 96% of the population is heterosexual and about 4% bi-to-homosexual. The estimate from the present investigation, that 95.6% of the population is heterosexual, is close to both previous estimates, especially considering that our sampling method was somewhat biased toward soliciting homosexuals. Judson et al[1] lament that they would have preferred to ". . . compute relative risks for each STD from . . . sexual preference-specific incidence rates in the general population. Unfortunately the necessary denominator data are not available . . ." appears to be largely met by the congruence of these three independently performed studies' estimates.

It would be better, of course, if an investigation that achieved very close to an one hundred percent acceptance rate could be performed; but given the degree of personal revelation involved in sexuality studies, it appears unlikely that the 96% estimate can be appreciably bettered by other than the Census Bureau with its power to coerce. The police were called at least once in every city in which we interviewed, and it is our impression that sexually conservative people were more apt to refuse to cooperate. So while our estimates are more representative than the various magazine or Kinsey sexuality surveys, they are still probably biased toward over-estimating the number of bi- and homosexuals.

Our estimates for syphilis reported in Table 1 are similar to those reported by the Centers for Disease Control for the past 27 years.[6] Our sex ratio (male:female) was 3:1 while the CDC's ranged between 1.5:1 to 3.2:1. While our homosexuals accounted for 41% of male syphilis, the CDC proportion ranged from 23% to 42%. The CDC appears to estimate about an equal division of genital warts experience for the genders[7] as we found. However, the CDS public clinic experience[7] suggests about 5 cases of gonorrhea for every case of condyloma acuminata, while we found a ratio of 1.6:1.

Sexually Transmitted Disease and Sexual Orientation

Handsfield[8] reported that in the largest sample of homosexual male volunteers, 78% admitted to at least one of the STDs surveyed. Sixty-eight percent of our randomly drawn sample of homosexual men admitted to at least one of the set of 11 STDs and 78% to at least one of the 15 STDs. Homosexual women's STDs were given short shrift apparently because the authors believed[2] that STD ". . . doesn't appear to be a problem among lesbians. In fact, lesbians have about the lowest rate in the country for venereal disease." Our investigation suggests that both male and female homosexuals are more apt to contract STDs than their heterosexual counterparts. Our gender-adjusted episode estimates indicate that homosexuals account for about triple their proportionate share of STDs or about 15% of all STD experiences in the cohort.

As with smoking, drug or alcohol use, or other habit systems, homosexuality may be abandoned or taken up depending on the values of the individual and the social pressures to which he is subject. Many of the homosexuals had been or were married (32% of the males, 47% of the females); only 8% of the male and 5% of the female homosexuals claimed virginity, while those who detailed their heterosexual encounters claimed medians of 3 and 5.5 partners for the male and female homosexuals, respectively (vs. medians of 20 and 3.5 for the number of homosexual partners). 0.3% of those who currently designated themselves as heterosexual claimed once to have been in a homosexual 'marriage', while 7% of these males and 3.1% of the females admitted to at least one homosexual partner in their life; and 0.7% of these males and 0.4% of the females admitted to on-going homosexual relationships. Similar to drug or other habit systems, some movement between the categories of sexual orientation in both directions occurs. A recent study[9] of 50 wives who reported having had no homosexual experiences or interests up to age 30, but who participated in homosexual sex acts as part of swinging, reported that all eventually came to self-identify as bi-sexual. As part of our ongoing effort, we sampled 842 adults asking them if they had ever considered themselves homosexual. Almost 2% of those registering themselves as heterosexual claimed to be ex-homosexuals.

The finding that those who reported absolutely no homosexual contact should have the lowest STD rate suggests the unhealthful nature of homosexual activity. Since people do not always know the sexual histories or current sexual habits of their partners, the possibility that homosexual activity accounts for an even greater proportion of STDs than reported in Table 1 is considerable. Since a large fraction of homosexual practitioners go "both ways", homosexuals constitute an important vector of infection for the entire society. Diseases ranging from typhoid fever[10] to the various forms of hepatitis may be transmitted sexually, but food and blood handling can also transmit many of these diseases and some may be transmitted as microbial aerosols.[11] The extent to which persons who engage in homosexual acts decrease collective health would seem to warrant substantial attention.

Denver's STD clinic recently[12] reported that about 41% of their gonorrhea caseload was contributed by homosexual men. An earlier report from the same clinic[1] indicated that homosexual men generated about 30% of the male STD caseload. Our Denver sample did not differ from our overall sample in either incidence of homosexuality or the relationship between homosexuality and STDs. It would appear that the approximately 6% of the males who are bi- or homosexual in Denver generate between 30% to 41% of the caseload for this clinic maintained at public expense. In a society where approximately 10% of the Gross National Product is being expended on public health costs, such disproportionate utilization of a public benefit has serious social policy implications.

In a perfect world, those who had a communicable disease would do everything in their power to assure that others did not contract it. But ours is not such a world. Homosexuals are not only disproportionately diseased, but they also claim to have more frequently deliberately infected others. When the disease is something that can be readily treated, as with genital lice, the social policy implications are minor. But the homosexual population is currently the chief carrier of the most deadly STD of all in AIDS. While the exact mode of transmission of AIDS is unknown, it appears highly likely that it can be transmitted both sexually and through blood products. While attempts to encourage homosexuals not to donate or sell their blood for population use have been made, some homosexual leaders have been quite public about the power their disease confers upon them. Robert Schwab,[13] a leading gay activist in a public statement reported throughout the U.S. homosexual press, called for the possibility of "blood terrorism" unless homosexuals had their various demands met. The MacNeil-Lehrer News Hour of September 16, 1983, reported that a Minneapolis homosexual, who had been working at a blood bank, contracted AIDS and got so "distraught and discouraged about his condition", that he went to Chicago and "pretended that he didn't have AIDS" and engaged in sexual relations with at least one unsuspecting male. How often this "thoughtlessness" occurs cannot be known with certainty, but in a subpopulation where hurtful forms of sexual pleasure (e.g., B & D, S & M, handballing, oral/anal contact) are common, it must occur with some regularity. The social policy implications of disproportionate deliberate and/or "thoughtless" infection are profound.

Interest in and involvement with the anus and rectal products has probably always characterized homosexuality. But the call for exploration of the "new virginity" (utilizing the anus for oral and manual sexual pleasure) by the nation's soft-porn establishment (e.g., **Penthouse, Playboy, Hustler**) seems to be stimulating new behavior on the part of the younger heterosexuals of both genders. A corresponding increase in the prevalence of many STDs is also evident. Removal of human waste from the food chain and environs, coupled with an emphasis upon cleanliness, is credited with a great deal of the better health of the present population. Reversal of this standard by tying anality to sexual practices is a trend with frightening medical and social implications. Whereas past cohorts might have developed some immunity to fecally borne disease out of considerable regular exposure,[15] the population today is far more vulnerable. The "sexual revolution" may be undoing in the name of "fun" many of the hygenic and sanitary advances of our civilization. There are public health problems here that cannot be safely ignored.

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Lymphoid Malignancies in Nebraska: A Hypothesis

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Hypothesis

RESIDENTS of Nebraska have a significantly increased risk of death due to lymphoma and leukemia when compared to the national average.[1] The risk of death due to leukemia is increased for both males and females. Males also have an increased risk of death due to Hodgkin's disease (HD) while females are at risk for non-Hodgkin's malignant lymphoma (NHL).[1] The mortality rate due to NHL in Nebraska increased by 50% between 1950-1959 and 1970-1979 compared to an increase of approximately 40% nationally for the same time periods.[1] In a cluster of six counties in the Platte River Valley of central Nebraska, the incidence of leukemia and lymphoma is twofold greater than the national average.[2] In those same counties, the incidence of lymphoma is fourfold greater than in the adjacent state of Wyoming.[3] The factors responsible for the increased incidence and risk of death from lymphoid malignancies in Nebraska are unknown. Recent death certificate studies investigating the association between farming and cancer have indicated that midwestern farmers have a higher risk of leukemia and lymphoma than other occupations.[4-9] The risk of leukemia and lymphoma was greatest among farmers born after 1900 and dying before age 65. These findings suggest that recent changes in agricultural techniques and practices, such as the increased use of pesticides and fertilizers, may be involved in the genesis of lymphoid malignancies in Nebraska.[4-10]

Rationale

Agriculture is a major industry in Nebraska. The widespread use of chemicals, such as manufactured fertilizers and synthetic pesticides, is one of the most characteristic features of the modern agricultural era. This period, dating roughly from World War II, has been marked by rapid and fundamental changes in agricultural production methods. Because agricultural chemicals have enabled farmers to obtain higher yields per unit of land with lower labor requirements and lower overall production costs, their use has become a standard feature of most of this country's major agricultural systems. The total use of fertilizers and pesticides has increased more than sevenfold in the United States since 1945.[11] More than 250 million acres of U.S. agricultural land is now treated with herbicides, compared to only 50 million acres in 1960. The use of herbicides in the U.S. has risen from 227 million pounds of active ingredients in 1966 to approximately 625 million pounds in 1981, an increase of 175%.

In eastern Nebraska, the major crops are corn, soybeans and grain sorghum.[12] Of approximately 17 million acres of major crops (excluding pastures and rangeland) grown in Nebraska in 1982, 11 million acres were treated with herbicides and over 5 million acres with insecticides.[12] In Nebraska, corn was the major crop in terms of pesticide usage with over 90% of the planted acreage treated with herbicides and over 60% treated with insecticides. Of the acreage planted in soybeans and grain sorghum, over 90% was treated with herbicides. In terms of total treatment, more than 30 million pounds of active pesticides were applied to major crops, pasture, and rangeland in Nebraska in 1982, with the majority of this applied to corn acreage.[12] An overwhelming majority of livestock producers in Nebraska also use pesticides.[13] The following is a breakdown of each of the livestock commodities and the percentage of producers using pesticides: beef cattle 99%, feeder cattle 95%, dairy cattle 98%, swine 95%, poultry 86%, horses 88%. Clearly, the potential for health problems arising from the use of agricultural pesticides is great in Nebraska.

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Certain herbicides and herbicide-contaminants have been associated with teratogenesis, mutagenesis, and carcinogenesis in animal and bacterial experiments.[14] Strong epidemiologic evidence linking herbicide exposure to the development of lymphoma was recently reported from Sweden where, in a case-control study, the risk of lymphoma (HD and NHL) following herbicide exposure was increased fivefold.[15] Herbicides implicated as causative factors in lymphoma were the phenoxy acids and chlorophenols, and the risk was increased whether or not these herbicides were contaminated by polychlorinated dibenzodioxins or dibenzofurans. Chlorinated phenoxy acids have been widely used in the United States as herbicides in corn and wheat production.[16] The mechanism of lymphomagenesis due to these agents is unclear. Dioxin causes immmunologic depression characterized by thymus gland involution, lymphopenia and suppression of cell mediated immunity in laboratory animals.[17] The phenoxy acids are mutagenic agents which damage DNA in laboratory animal systems, suggesting that they have significant carcinogenic potential.[18] The chlorophenols have been shown to cause an increased incidence of lymphomas and leukemias in rats.[19] A widely used agricultural soil fumigant, 1,3-dichloropropene, has also recently been linked to the development of lymphoma and leukemia in man.[20] This chemical is structurally similar to vinyl chloride and is strongly mutagenic in bacterial test systems. Lymphocyte chromosome analysis of pesticide workers, who are at an increased risk to develop leukemia,[21-23] has shown a marked increase in the frequency of chromatid lesions during heavy spraying periods.[24] These studies suggest that depressed cellular immunity and lymphocyte DNA chromatid damage may be important in the pathogenesis of lymphoid malignancies associated with pesticide exposure.

Goldsmith and Guidotti[25] have estimated that one-third or more of all cases of NHL may have an environmental or occupational basis. Death certificate studies of leukemia in Nebraska[4] and Iowa[7] have revealed an elevated risk for farmers of approximately 25%. The excess of leukemias appeared to be largely of the lymphoid type. Stratification of cases by county showed a significantly increased risk for farmers from heavy corn producing counties.[4,7] The risk for leukemia was greatest among farmers born after 1900 and dying before age 65,[4,7] and in this age group the highest risk was associated with residence in counties with high herbicide[7] or insecticide[4] usage. A similar study of NHL in Wisconsin[8] showed a 70% increase in risk for farmers dying before age 65, with the highest risk occuring in counties with high agricultural activity, and high herbicide and insecticide usage. Young farmers in Wisconsin were at a much higher risk for the development of large cell (histiocytic) lymphomas than the other cell types of NHL. We have also noted a disproportionate number of large cell (histiocytic) lymphomas among the recently recorded cases in the files at the University of Nebraska Leukemia/Lymphoma Registry, as compared to the national average.[26] The markedly increased risk of leukemia (80%) and lymphoma (70%) in young farmers in Nebraska[4] and Wisconsin,[8] respectively, suggests that exposure to one or more agricultural chemicals, first introduced and used in significant quantities in the late 1940's and early 1950's, may be important in the etiology of lymphoid malignancies in farmers. The average latent period for the induction of leukemia after exposure to chemical agents or ionizing radiation is approximately 10 years.[15] The latent period is presumably similar for lymphomas, although the two cases associated with 1,3-dichloropropene poisoning occured after a period of only five years.[20]

Eastern Nebraska is an area of high agricultural activity. The 30 Nebraska counties with the highest levels of corn production, fertilizer, insecticide and herbicide usage are in eastern Nebraska.[4] (Figure 1) A cluster of such counties is present in and adjacent to the Platte River Valley (Figure 1). The excess of leukemia and lymphoma in Nebraska appears to occur largely in eastern Nebraska,[1] with the central Platte River Valley being a known high incidence area.[2, 3] The eastern Nebraska counties with an increased mortality rate due to leukemia and lymphoma also tend to cluster somewhat along the entire eastern Platte River Valley (Figure 2). An increased mortality rate due to NHL is also present in Holt county in northeast Nebraska, and an increased mortality rate due to HD is present in southeast Nebraska (Figure 2). Burmeister et al[7] have suggested that the increased risk for farmers of leukemia and other cancers may be related to

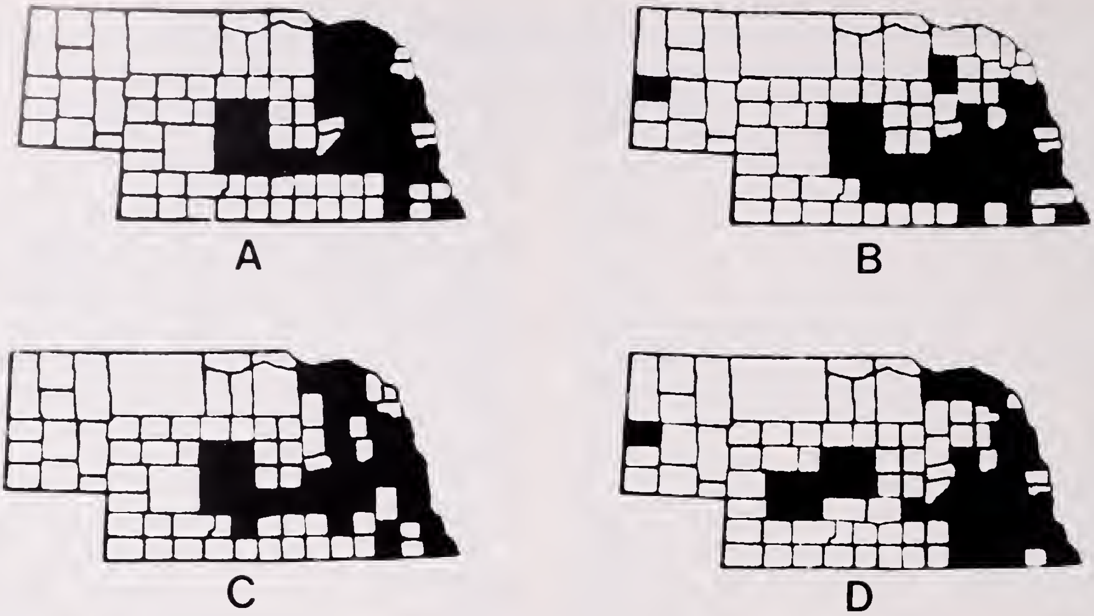

Figure 1
Geographical distribution of the 30 Nebraska counties with the highest levels for corn production (A), fertilizer (B), insecticide (C), and herbicide (D), usage.

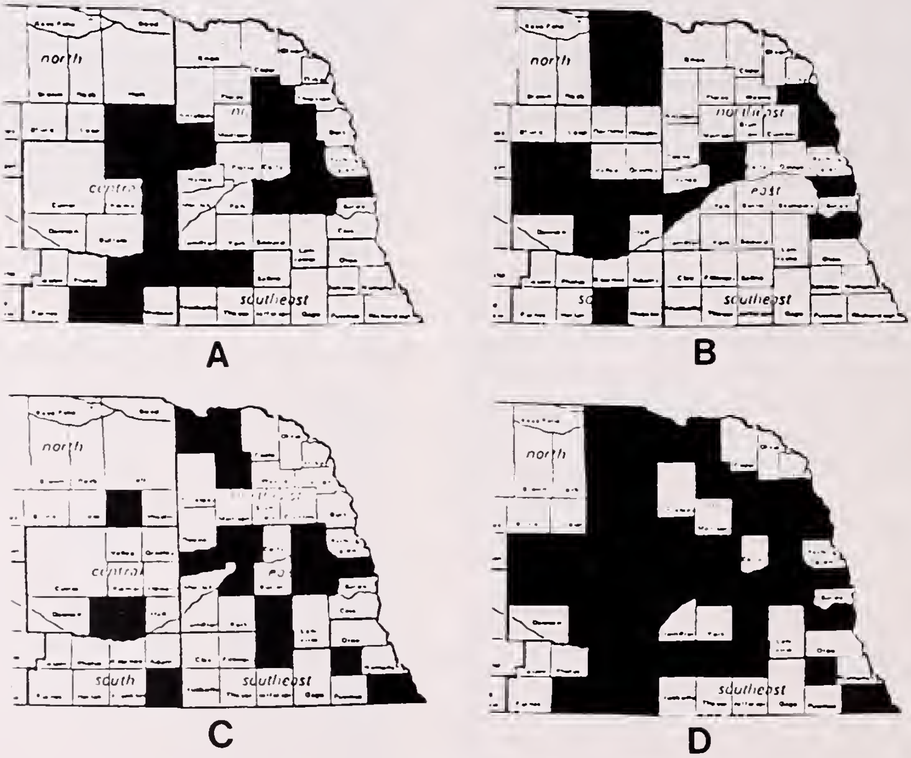

Figure 2
Geographical distribution of eastern Nebraska counties with significantly more male or female deaths than expected due to leukemia (A), non-Hodgkin's lymphoma (B), or Hodgkin's disease (C), 1960-1969 or 1970-1979; (D) A-C combined.

contamination of shallow farm wells and farm ponds. Shallow ground water in the central Platte River Valley, southeast Nebraska, and Holt county in northeast Nebraska, has been found to be heavily contaminated with nitrates, in excess of 10mg/1, due to heavy fertilization and irrigation, as well as barnyard and feedlot runoff.[27-29] The maximum allowable concentration of nitrate in drinking water is 10 mg/1.[30] Although nitrates themselves have not been found to be carcinogenic in animals or man, nitrates may be converted in-vivo into nitrites, which then may interact with other dietary components or endogenous metabolites to produce N-nitroso compounds which are potent carcinogens in animals.[31]

In Iowa, analysis of the lymphoma pattern by county suggested that counties that use water from shallow wells along major rivers contaminated with pesticides have a high incidence of lymphoma.[32] Studies of shallow well water in the central Platte River Valley and in southeast Nebraska have also demonstrated ground water contamination by several pesticides.[28,33,34] Traces of N-nitroso compounds have also been found in a number of pesticides.[35,36] Atrazine, a widely used pesticide in Nebraska, has been shown to react with nitrites to form N-nitroso compounds.[37] N-nitroso compounds have recently been shown to induce lymphomas in laboratory animals.[38] Shallow wells are a common source of drinking water on farms in Nebraska. These findings suggest that the contamination of ground water used for human consumption by pesticides and nitrates may be causually related to the increased incidence of lymphoid malignancies in Nebraska. If this is true, the increased risk of malignancy would extend beyond the farmer to other family members, and to adjacent communities using similar water sources.

A survey of Nebraska hospitals in 1983 revealed 24 reported cases of acute poisoning from pesticides during the 1983 growing season.[39] Twenty-one of the 24 cases were engaged in farm work or a farm support activity. It is probable that many other cases of acute poisoning are unreported. A residential telephone survey in Nebraska revealed that 52% (1979) and 50% (1980) of heads of households had pests in and around their homes, lawns, and gardens, and that 79% (1979) and 73% (1980) of those with a pest problem used pesticides.[40] This survey estimated that 250,000 Nebraskans use pesticides each year. The same survey revealed that 12% (1979) and 9% (1980) of household members became ill as the result of pesticides, compared to a national average of 3%. Fifty-three percent of these said that the ill effects were minor.[40] Nebraska's poison control center reported over 1000 calls in 1983 that were related to pesticide exposure.[39] Clearly, the potential for health problems arising from the use of agricultural and non-agricultural pesticides is great in Nebraska.

Farmers are rather self-sufficient and may individually perform tasks that are normally associated with other occupations. Since a farmer often functions as his own mechanic, carpenter, welder and equipment operator, he may also be exposed to other potential carcinogenic substances such as solvents, oils, fuels, welding fumes, and organic dusts. The development of lymphoid malignancies has also been linked to exposures to chemicals such as benzene and other organic solvents.[15, 41,42]

Future Studies and Possible Solutions

A unique opportunity to study and identify factors involved in the etiology of lymphoid malignancies is present in Nebraska. Blair and Thomas[4] and Cantor[8] have suggested that detailed epidemiologic studies of incident cases of lymphoid malignancy with matched controls, in which precise diagnostic and pesticide exposure information is gathered, are needed to fully evaluate these factors. The Leukemia/Lymphoma Study Group at the University of Nebraska Medical Center plans to carry out such a study in the near future. In addition, basic research concerning the role of nitrates, pesticides, and other chemicals in the pathogenesis of lymphoid malignancies is clearly needed.

Knowledge that would be gained from such studies is essential for the formulation of specific strategies to prevent these malignancies in Nebraska in the future. As examples, a positive association between pesticide use and leukemia or lymphoma should lead to an increased awareness of the dangers of these substances and to changes in agricultural practices concerning them. Over 80% of the pesticides used in Nebraska in 1982 were self-applied by the agricultural producer, and 78% of the applicators were certified in the safety of pesticide handling.[12] However, only 68% of the applicators used protective clothing and only 25% used filter masks while handling pesticides.[12] Agricultural practices to optimize weed control and to decrease the use of pesticides could be emphasized, such as mechanical cultivation, crop rotation, proper spacing of crop rows, burning, proper timing of crop plantings, biological methods, use of special crop varieties that resist competition from weeds, and seeding methods that promote crop growth and discourage the proliferation of weeds. Examination of the soil for pests and nitrate levels prior to the application of insecticides or fertilizers could be promoted, thereby decreasing the amounts of these substances that are applied unnecessarily. Also, an ongoing comprehensive survey for pesticides and nitrates in sources of drinking water in Nebraska could be implemented, and those sources found to be contaminated could be closed.

Summary

Residents of Nebraska have a significantly increased risk of death due to leukemia and lymphoma when compared to the national average. The factors responsible for this increased risk are unknown. Epidemiologic evidence suggests that the recent and dramatic increase in the use of pesticides and fertilizers in agricultural areas may be linked to the development of these malignancies. Further studies to better define the role of nitrates, pesticides, and other chemicals in the pathogenesis of lymphoid malignancies in Nebraska are clearly needed. Knowledge that would be gained from such studies is essential for the formulation of specific strategies to prevent these malignancies in Nebraska in the future.

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BUSINESS ASPECTS OF MEDICINE

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LOCATION - Generally, metropolitan practices in growing suburbs have more value than mid-size or rural communities. If you are in a resort area or a ski area your value increases. Practices may sell for as much as "a year's net" in a desirable area.

EQUIPMENT - Equipment generally has little value over "fair market" or "book value" except as a part of your total "on-going" practice. Therefore, a conservative value between "fair market" and depreciated "book value" is probably an accurate evaluation in an appraisal.

REAL ESTATE - If you own your clinic building it generally makes a total practice and clinic sale more difficult to negotiate simultaneously. There is a tendancy for the buyer to purchase the clinic real estate and ask that the practice be "thrown in" or at a greatly reduced value. Therefore, it may be more effective and certainly less complicated to negotiate the sale of the practice and it's assets with an option for the building purchase at a later date.

SPECIALTY - Some specialties have a reduced value due to the difficulty in transferring patients allegiance. Generally the higher percentage of patient referrals (versus physician referrals), the higher the value.

GROSS/NET INCOME - This is the heart of the monetary attractiveness of any professional practice. In theory, the value of a practice is generally only the practice's "excess earnings" capability. As an example, if a family practice physician's average (nationally) is $77,000 net per year, then a practice netting $110,000 per year would have $33,000 "excess capitalization". This translates into a "goodwill multiple". The higher the multiple, the higher the practice value.

ACCOUNTS RECEIVABLE - It is difficult to value (called: "discounting") accounts receivable. Therefore, normally they are not valued or included in the practice sale. The buyer may receive a fee for collecting the accounts receivable on behalf of the seller.

DEDUCTABILITY - Generally in a practice sale, what is good for the buyer is bad for the seller, and vice versa. This is a difficult area to assess because each and every physician has a varying tax situation. Your own tax counsel should certainly be called. The more tax liability you assume, the higher the sale price.

TERMS - Each negotiation is unique. We are dealing with an advisory relationship, whereby the seller wants "cash at closing" and the buyer wants a "payout based upon the future earnings". Usually both parties compromise, partially dictated by what a lending institution will finance.

TIMING - In the words of Jack Benny, "TIMING IS EVERYTHING". Once you begin "cutting back" on your patient load, the value of your practice drops perceptually. The buyer will be concerned that the downward trend cannot be halted. A word to the wise . . . START EARLY!

CONCLUSION - It is impossible to "broadbrush" this entire area with a hard and fast methodology for every practice sale. In reality your practice's fair market value is the price at which the practice would change hands between a willing buyer and a willing seller; neither being under any compulsion to buy or sell and both having a reasonable knowledge of the relevant facts.

It is important to properly price your practice to sell at a fair market figure. The average physician overprices, but eventually accepts a price below the "fair market value".

*The author is President of the RH Medical Group, Inc., a Practice Appraisal, Brokerage and Physician Search Firm with its home office in Houston, Texas.

President's Page

THOUGHTS ON ETHICS ON RATIONING

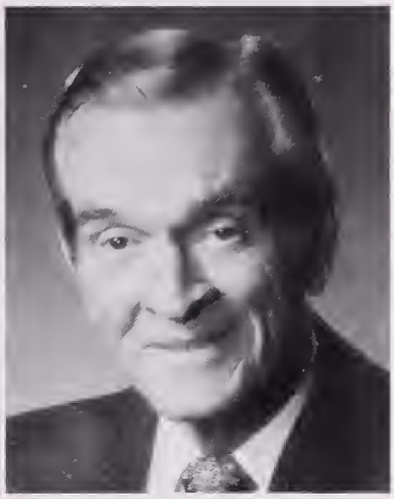
PART I

The rising interest in medical ethics in recent years is illustrated in the increased volume of such articles being published in medical journals. From 1979 to 1983 2,574 articles appeared and in 7 of the most popular journals 842 were published from 1971 to 1984 along with 15,734 references made to ethical topics. The reason for this interest is the many problems confronting physicians and hospitals emanating from the avalanche of drastic changes in the health care field.

This piece (Part I and II) is concerned with only one aspect of ethics — that which applies to rationing of care with special emphasis on the medicare segment as they will be affected more than others. Improving the access to health care was the centerpiece of federal health policy in the '50's '60's and '70's. This proved successful but no provisions were made to control costs. Starting in the late '70's the federal and private sector of health planning have been totally preoccupied with a needed cost reduction. The far reaching constraints imposed on the medical field to accomplish this are designed to shrink systems and reduce access to health care. This is resource allocation, a euphemism for rationing.

In February of this year the United States General Accounting Office furnished Senator Heinz, Chairman of the Special Committee on Aging, with a detailed report on the plight of medicare patients. This information in the report left no doubt the quality of care has lessened, prompting him to remark that medicare patients are being dismissed quicker and sicker and if moved to post-hospital facilities they often go from poor care to no care zones.

The PRO, DRG, CON, professional liability, anti trust action, state and federal legislatures, corporization, new health care delivery systems, insurance industry have all contributed to the many restraints tending to control costs by limiting access. One notable contradiction has been the Baby Doe regulation in which costs are to be ignored as well as the worth of the contemplated therapy.



Francis D. Donahue, M.D.

Another concern other than rationing is the thought of how a jury will respond when economic rather than medical considerations are offered as a reason for diagnostic or therapeutic decisions that led to a malpractice claim. Most plaintiff attorneys regard any action less than that of the loaves and fishes to constitute malpractice but a physicians negligence in court should be measured against existing professional standards not economic considerations. It is important to note those eager to apply strong regulations have arranged these in such a fashion the painful decisions of balancing costs and quality of health care are passed on to the provider who will be held accountable. Needless to say we have many concerns brought on by these regulations, the fate of quality of care and our ethical responsibility are in the fore front.

Francis D. Donahue, M.D.
President

The Auxiliary

STATE CONVENTION 1985

The Nebraska Medical Association Auxiliary met at the Cornhusker Hotel in Lincoln, celebrating their 60th annual meeting.

The Annual Board Meeting, chaired by President Helen Krause, started the 3 day gathering of the Nebraska Auxiliary.

A luncheon, welcoming all, was held at the Cornhusker followed by a seminar "Calling the Shots, The Advertising of Alcohol" by Becky Beardsley from the Lincoln Council on Alcohol and Drugs.

Friday evening a progressive dinner was enjoyed with gracious hosts, Mrs. George Gammel and Mrs. L. Palmer Johnson opening their homes for our enjoyment. Many thanks to these ladies and the Lancaster County Auxiliaries who worked to make this such a pleasant evening.

On Saturday the guest speaker at our Awards Brunch was Billie Brady (Mrs. Wayne C.), President of the American Medical Association Auxiliary.

Billie, who is from Greenville, South Carolina, was elected president-elect at the AMA Auxiliary Convention in June 1983, and took office as president at the 1984 Convention. She has been active on the national level since 1975, holding many positions.

We were honored to have Billie with us to encourage continued activity by our State Auxiliary, to increase membership, and to establish a good working relationship with our Nebraska Medical Association. She reminded us of the importance of our volunteerism in our communities, especially concerning health projects.

It was a privilege to have her install our new officers. During our awards luncheon it was a highlight to hear the names of our "Woman of the Year" who is Helen Mahon, Norfolk and "Merit Award" winner, Jane Taylor of North Platte.

How thrilling to listen to the list of their activities and achievements and know they are a part of the organization, plus to know we are achieving its purposes, which are:

To assist in the programs of the American Medical Association that improve the health and quality of life for all people; to promote health education; to encourage participation of volunteers in activities that meet health needs; and to support health related charitable endeavors.

Donna Stone, our very busy A.M.A.E.R.F. chairman, thrilled us all with her $7,181.45 total contributions. This is an increase of $1,535.48 over the previous year. If you did not buy a loaf of her homemade bread (all monies going to A.M.A.E.R.F.), you missed a special treat. Leading in contributions was Lancaster County.

Colleen Adam, Nebraska Medical Foundation chairman, announced contributions amounting to $2,859.08.

It was a joy to have as special guests our Past Presidents: Mrs. J. Whitney Kelley (Irene), Mrs. Fay Smith (Jo), Mrs. Robert McIntire (Marilyn), Mrs. Leland Olson (Dorothy), Mrs. James Carlson (Barb), Mrs. Warren Bosley (Alleen), Mrs. Y. Scott Moore (Patsy), Mrs. Gordon Francis (Harriette), Mrs. Guy Matson (Dodie), Mrs. Harry Shaffer (Dorothy), Mrs. Clifford Hadley (Beth), Mrs. L. Palmer Johnsen (Shirley), Mrs. Bryce Shopp (Wanda), and Mrs. Glen Lau (Elba).

What a privilege to hand on the gavel to my dear friend and your new president, Ardis Grace.

We have been striving to carry out the objective of our auxiliary which states "A spirit of friendliness among physicians families." The annual meeting is an opportune time to renew and make new friendships.

Making friends and meeting people has been my bonus as Nebraska Medical Association Auxiliary President and I thank you, the members, for the privilege.

Respectfully,
Helen Krause

Officers for the 1985-86 Year are as follows:

President
  Mrs. Leslie Grace (Ardis), Blair
President-Elect
  Mrs. Robert Kruger (Bev), Omaha
First Vice-President
  Mrs. George Adam (Colleen), Hastings
Second Vice-President
  Mrs. Robert Osborne (Desta), Lincoln
Treasurer
  Mrs. William Schlichtemeier (Jeanette), Omaha
Recording Secretary
  Mrs. K. Charles Bagby (Carole), Blair
Corresponding Secretary
  Mrs. Glen Lau (Elba), Lincoln
Two Year Directors
  Mrs. Bryce G. Shopp (Wanda), Imperial
  Mrs. Stephen Nielsen (Nancy), Omaha

CREIGHTON UNIVERSITY SCHOOL OF MEDICINE NEWS

New Dean of Students at C.U. Medical School

Dr. William Pancoe, assistant dean for student programs at the University of Wyoming College of Human Medicine, will join the Creighton School of Medicine July 1 as professor of physiology and associate dean for student affairs.

Pancoe has held his current position at Wyoming since 1977 and earned his Doctor of Philosophy Degree in medical physiology/endocrinology at Colorado State University.

He succeeds Dr. Matthew Severin as associate dean in the Creighton medical school. Severin is taking an administrative leave to finish his studies toward a law degree. He will then resume his responsibilities as professor of medical microbiology and set up a program in medical jurisprudence for Creighton medical students.

Pancoe has worked closely with Creighton for 10 years as contract officer for Wyoming's health sciences programs and has been deeply involved with the admission of students from Wyoming to the Creighton medical and dental schools.

He joined the Wyoming faculty in 1964 and holds the academic rank of professor. He has numerous scientific publications and has distinguished himself as an outstanding research advisor for graduate students.

Dr. William Pancoe

Pancoe is a fellow of the American Association for Advancement of Science and a board member of the Colorado-Wyoming Academy of Sciences. He is a member of the American Physiological Society and the American Zoological Society. He also is the Whedon Cancer Detection Foundation's assistant director for research.

Welcome New Members

Tom De Meester, M.D.
601 No. 30th St.
Omaha, NE 68131

Gerald C. Felt, M.D. (reinstated)
6801 N. 72nd St.
Omaha, NE 68122

Ernest W. Chupp, M.D.
2430 So. 73rd
Omaha, NE 68124

Coming Meetings

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — DR. JOHN S. LATTA CENTENNIAL LECTURESHIP — August 29-30, 1985, UN Medical Center, Omaha, Nebr. Speaker: Dennis G. Osmond, M.B., Ch.B., D.Sc., F.R.S.C., the Robert Reford Professor of Anatomy at McGill University, Montreal, Quebec. Thursday, August 29 — Latta Lecture: "Understanding the Immune System: Changing Perspectives" — 12 noon, UNMC campus. Friday, August 30 — Medical Grand Rounds: "The Contribution of the Bone Marrow to the Immune System: B Lymphocyte Production, Differentiation, Localization and Regulation" — 12 noon, Bishop Clarkson Hospital, Storz Pavilion, Omaha, Neb. Everyone invited.

EMERGENCY MEDICINE REVIEW — September 23-28, 1985 and will be repeated on October 1-12, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. Credit: 45 hours AMA Category I, AAFP Prescribed & ACEP Category I. Fee: $425 physicians, $325 residents in training. Content: This course will provide physicians engaged in the evaluation and treatment of urgent and life threatening conditions with an in-depth review of emergency medicine. Special attention will be given to the recognition of conditions that must be identified immediately, and evaluation of nonemergency conditions. Daily national board type exams will be given. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Cocktail Reception — Friday, October 11, 1985, 5:30-7:00 p.m., in conjunction with the American Academy of Family Physicians Meeting, Marriott Hotel, Anaheim, California. All alumni, spouses and friends are invited. Cash bar.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Roundup and Reception in Omaha, Monday, October 28, 1985, 6:00-7:00 p.m., Red Lion Inn Ballroom; in conjunction with the Omaha Mid-West Clinical Society Postgraduate Assembly. Cash bar. All alumni, spouses, faculty and friends are cordially invited. Followed at 7:45 p.m. with 50-year dinner in Nebraska Room, Red Lion Inn. Class reunions will be held in Omaha at the end of October for classes ending in "5" and "0".

CREIGHTON UNIVERSITY

ANGIOPLASTY — Aug. 10, 1985, Room 6712, Saint Joseph Hospital, Omaha, Nebraska. Creighton Premiere Rounds, 8:00-9:00 A.M.

FAMILY MEDICINE UPDATE — Aug. 30-31, Sept. 1, 1985, The Lodge at Okoboji, Okoboji, Iowa. Program Director: Fred J. Pettid, M.D., Department of Family Practice, Creighton University. Topics include office cardiology, high risk obstetrics, office urological problems, dermatology, and medical-legal issues. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

GYNECOLOGIC MALIGNANCIES — Sept. 27, 1985, Boystown National Institute Auditorium, Omaha, Nebraska. Co-sponsored by the departments of medicine, surgery, obstetrics and gynecology and Saint Joseph Hospital for primary care physicians, general surgeons, gynecologists, and nursing personnel. Program Director: James A. Mailliard, M.D., Division of Oncology, Creighton University. For information: Division of CME, Creighton University.

HEART AND MIND — Oct. 10-12, 1985, Marriott's Tan-Tar-A Resort, Lake of the Ozarks, Osage Beach, Missouri. Program Directors: Emmet M. Kenney, M.D. and Syed M. Mohiuddin, M.D. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

HEART AND MIND: NEUROCARDIOLOGY UPDATE — September 7, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

ANNUAL SURGERY SYMPOSIUM — September 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

KANSAS CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS MEETING — September 14-15, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — September 19-20, 1985, November 14-15, 1985. Sponsor: University of Kansas Medical Center, Department of Otorhinolaryngology. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA Category I. Fees: $625. Maximum Enrollment: 9 persons per session.

MEDICINE AND RELIGION: The Supreme Being, the Supreme Court, and the Almighty Dollar — October 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow

Blvd., Kansas City, Kansas. Target Audience: Physicians, Nurses, Clergy, Social Workers, Nursing Home Administrators. Contact: Promotion Coordinator, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4488.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

2ND MIDWEST REGIONAL CONFERENCE ON WOMEN IN MEDICINE — September 27, 28, and 29, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri. Credit: 8 hrs. AMA Category I, 8 hrs. AAFP. Fees: $130 Physicians, $60 Other Health Professionals, $20 Students. Guest Speaker: Ellen L. Shulman, M.D., NASA, Lyndon B. Johnson Space Center, Houston, Texas.

ANNUAL INTERNAL MEDICINE SYMPOSIUM — October 9, 10, 11, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

53RD ANNUAL POSTGRADUATE ASSEMBLY — Omaha Mid-West Clinical Society, October 28, 29, 30, 1985, The Red Lion Inn, Omaha. For information contact Miss Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 7363 Pacific Street, #205-B, Omaha, Nebraska 68114.

WashingtoNotes

(Continued from page 12a)

—develop methods of service delivery that will encourage care in the home yet reduce the stress on families of patients, and

—increase the training of health care professionals to improve the diagnosis, treatment, and management of the disease.

"Alzheimer's disease demands special attention," said Rep. Roybal. "My bill is proposing a substantial step forward in funding for research and a beginning step in support for the families."

Next year, he says he will introduce a larger and more comprehensive bill for Alzheimer's patients and their families. Congress should boost funding for the disease "severalfold," he said. "The federal government must do more."

* * *

Senior Citizens Decry Drug Testing

Elderly residents of nursing homes have been used in drug experiments without their knowledge or informed consent, according to documents obtained by the National Council of Senior Citizens.

At least eight physicians who contracted with nursing homes to test experimental drugs violated federal law by using harmful tests and practices, internal Food and Drug Administration (FDA) documents reveal.

Some of the investigators have been permanently disqualified by the FDA; others have been temporarily disqualified or reprimanded.

In some cases, drugs were given surreptitiously in food. In other cases, they were given to persons with mental infirmities or who could not speak English. Many patients had pre-existing health conditions or were too old to safely participate in testing.

Physicians implicated in the FDA investigation say that the majority of testing is performed in a careful and responsible way. Overly restrictive FDA regulations, if followed to the letter of the law, would prohibit the majority of drug testing in the elderly, they respond.

For instance, it is virtually impossible to find an 85-year-old who is disease-free and not taking other medications, said Richard Morris, M.D., medical director of the skilled nursing home Chester Extended Care Center. Dr. Morris was investigated by FDA but the agency has since dropped any action against him.

The Council has asked that all drug testing be immediately suspended in nursing homes where there is suspicion of abuse or past record of violations. Congress should investigate whether drug testing in nursing homes should be prohibited except under highly restrictive conditions, the Council said.

* * *

Senate Witnesses Drub Herbal Medicine

Manufacturers of non-prescription diet drugs should be required to prove that their products are safe and effective, just like pharmaceutical manufacturers, scientists urged legislators at a May congressional hearing.

"I do not believe that the makers of herbal medicines should be treated any differently than the makers of medicines of other kinds," said Varro E. Tyler, Ph.D., dean of the School of Pharmacy at Purdue University and an authority in herbal medicine.

"The public needs to be protected from false claims that can empty its pocketbook and destroy its health," said Xavier Pi-Sunyer, M.D., associate professor of medicine at Columbia University.

Under current law, the government has the burden of proving that a diet scheme will not work as advertised. Manufacturers often try to find flaws in the government's case or delay legal proceedings, thus prolonging their sales of the product.

Herbalife International, the largest U.S. distributor of health products, came under fiercest attack by those attending the hearing of the investigative subcommittee of the Senate Committee on Governmental Affairs.

Although the $512 million-a-year company is prohibited from making medicinal claims for its products, it now uses testimonials from customers on cable television. Overweight persons are vulnerable consumers who are often embarrassed to admit that a product did not work, noted subcommittee staffers.

The FDA has recieved four reports of death, 90 complaints of illnesses and 32 reports alleging fraud by consumers of Herbalife products. Although no definite conclusions have been reached about the safety of the product, further investigation seems warranted, legislators said.

Subcommittee Chairman Sen. William V. Roth Jr. (R-DE) urged FDA to pay more scrupulous attention to the adverse reactions of the product. But the FDA needs a clear directive from Congress before regulating the diet industry, FDA Commissioner Frank E. Young, M.D., responded.

The claims made for Herbalife products are false and deceptive, scientists testified. Most herbs do not produce the therapeutic effects claimed for them, they said. Even if the herbs had such effects, the Herbalife doses are too small to have any physiological impact, they added.

Moreover, the products may be toxic to consumers. Some of their components — such as schisandra, tong kuei, caffeine, and some laxatives — could pose health problems to unsuspecting buyers, they said.

* * *

Congressional Budget Bleak for Physicians

Legislators, just returning from a Memorial Day recess, were expected during the first week of June to enter a new round in their annual wrestling match with a federal budget measure.

The action now moves to a conference between the House and the Senate where the Senate is considered likely to back away from its proposal to freeze cost of living adjustments for Social Security and other retirement plans and the House is expected to compromise somewhat on its plan to freeze defense spending.

Debate will also involve the Medicare program where the House has rejected the Senate approach of increasing some beneficiary cost-sharing and of exempting some Medicare "participating" physicians from a plan to continue the current freeze on Medicare fees. Medicaid, too, is an issue since the Senate assumed savings of $1.2 billion over three years while the House would permit inflation adjustments for this program.

The cliff-hanging Senate vote came in the wee hours of the morning on May 12 as California Republican Pete Wilson, recuperating from an appendectomy, arrived by ambulance to tie the vote. Vice President George Bush cast the deciding vote.

The Senate package would cut Medicaid by $1.2 billion in the next three years through "administrative actions." Medicare would be cut by $16.3 billion over the next three years and the current freeze on Medicare fees would continue for "nonparticipating" physicians. Some sort of a fee increase is assumed for physicians "participating" but details have not been worked out.

Hospital diagnosis related group (DRG) rates would be frozen. The adjustment for indirect costs of graduate medical education would be cut in half and the payment for direct graduate medical education costs capped. The measure also would increase the premiums beneficiaries pay for medical services (Part B) under Medicare from the current 25% of costs to 30% of costs.

The House plan, adopted May 22, had a surprisingly smooth passage and no substantive debate on health issues. Much vaguer in its assumptions that the Senate measure, it calls for $13 billion in Medicare savings over the next three years. Some $3 billion is to come from unspecified reforms that are not to include beneficiary cost increases; another $10 billion is to come from a "one-year freeze" on Medicare providers.

While the proposal does not spell out any details, the size of the savings, the lack of any language to the contrary, and reports from House budget staff lead to the conclusion that the freeze on providers includes a continued freeze on all physician fees. There are some indications, however, that many House members would be willing to accept the Senate provision increasing fees for physicians who signed Medicare participating agreements.

Congressional members have reported, however, that although the American Medical Association and other medical groups have strongly protested budget proposals to continue the current Medicare freeze, individual physicians have not expressed significant opposition to this proposal. Their comments have sparked a massive AMA campaign to encourage physicians to communicate their concerns about the budget — particularly the continuation of the physician fee freeze and the cuts in Medicare support of graduate medical education — to their legislators.

Once a compromise has been hewn out by conferees and approved by both the House and Senate, action will move to the Congressional authorizing committees which are directed to meet the budget resolution's specific spending targets for programs under their jurisdiction but can choose their own method of meeting them.

This so-called reconciliation process is likely to begin in Mid-June and for Medicare and Medicaid programs will involve the Senate Finance and House Ways and Means and Commerce Committees. An adjustment in the physician fee freeze and increases for at least part of the Medicare participating physicians are considered to have a chance of approval during this process.

Other provisions that could be included in a reconciliation package include bringing state and county workers into Medicare, freezing payments only for certain procedures, an experimental physician prospective payment system, capitation payments and increases in cigarette taxes.

* * *

GAO Finds Hospital Overpayments

Hospitals have been overpaid under Medicare's prospective pricing system and unless the data the rates are based on are corrected, overpayments could total over $8 billion during the next five years, the General Accounting Office (GAO) has concluded.

In testimony to the House Ways and Means health subcommittee May 14, GAO Associate Director Michael Zimmerman charged that as a result of errors made during the construction of the diagnosis related groups (DRGs), Medicare payments to hospitals will be 4.3% or $940 million higher in fiscal 1986 than they should have been.

The GAO report comes as Congress is considering a freezing DRGs next year and it could serve as a rationale for such a freeze. The Prospective Payment Assessment Commission (PROPAC), which Congress created to give advice on DRG rates, has recommended a formula under which rates would increase 1-3% next year.

If rates are allowed to rise according to the current legislated schedule, the result would be an increase of about 5.1% next year.

But Health Care Financing Administration (HCFA) officials plan to propose regulations June 3 that would freeze the rates. Like the GAO, HCFA contends that the rates were set too high initially.

Hospitals are citing the PROPAC recommendation as evidence that a freeze is untenable, and American Hospital Association officials have told Congress that unless other changes are made in the DRG system, hospitals need at least a 4% increase in fiscal 1986 are to continue services at their current level.

Yet, the AHA and other hospital groups seem resigned to the freeze. At this point they are only pushing for changes. Chief among these are: an increase for hospitals serving a "disproportionate share" of indigent and/or Medicare patients; changes in the wage indexes believed to discriminate against rural hospitals; and some sort of protection for hospitals whose rates would be "rolled back" and not just frozen under President Reagan's budget proposal.

The "disproportionate share" issue has drawn the most attention. Congress had suggested when it created DRGs that an adjustment might be needed for the "disproportionate share" hospitals and had directed the Health Care Financing Administration to define and list such hospitals. HCFA has refused to design an adjustment or to turn over to Congress its studies and data on the issue, but the agency now expects a new study by the end of June.

Meanwhile, an angry Ways and Means health subcommittee is working with the American Hospital Association to design its own list. By one estimate, an adjustment might shift about $250 million to these hospitals from all other hospitals.

HCFA has only recently modified a wage price index to take into account parttime employees widely used in rural hospitals, based on a survey of 5,734 hospitals. Overall, hospitals in 27 states (generally in the west and midwest) and the District of Columbia would gain in Medicare payments. Twenty-three states (mostly East of the Mississippi) would suffer overall losses. But the effect would vary by hospital within a state. Slightly more rural areas (27) would profit than would lose (21) and slightly more urban areas (166) would lose than would gain (149).

Congressmen from states that would profit under the new wage index urge that it be applied to new DRG rates to take effect next October. There is general agreement that there should be no retroactive adjustment.

Although most hospitals agree that both the disproportionate share adjustment and the wage index correction should occur before a freeze, the industry is divided on a proposal to halt the transition to a national DRG rate. As the transition continues, teaching institutions, public hospitals, and facilities in high cost states such as California, Illinois, Massachusetts, Missouri, Wisconsin, and Ohio will be paid less while other facilities in states such as Alabama, Arkansas, Georgia, New Jersey, Pennsylvania, Tennessee, and North Carolina will see substantial gains.

Normally, the annual update in DRG rates would have alleviated the impact of the transition. But if rates are frozen, some hospitals will receive considerably lower payments per case in fiscal 1986 than in 1985.

A coalition that includes the Association of American Medical Colleges, the National Association of Public Hospitals and several state associations wants to stop the transition and Rep. Robert Matsui (D-CA) has introduced legislation to this end. The AHA supports the delay and the Federation of American Hospitals board is split on the issue. Another group of nine state associations is opposing any delay.

* * *

Attitudes on HMOs Changing

Although most American physicians still think traditional fee-for-service medicine offers higher quality care than HMOs, 50% of all physicians now have a favorable attitude toward HMOs. Furthermore, HMO patients express greater satisfaction with the quality of their physicians than do non-HMO members.

These results from a just-published survey by Louis Harris Associates contrast with earlier surveys which found in 1980-81 that only 36% of physicians were favorably disposed toward HMOs and that non-HMO patients were more satisfied with the quality of their physicians than were HMO members. Conducted last fall for the Henry J. Kaiser Family Foundation, the survey results are cited as "dramatic evidence that physicians have changed their outlook on HMOs."

The survey found that about 9% of privately-insured American families now have an HMO member and that 40% of those interviewed were interested in joining an HMO. Among the elderly who have been targeted for an HMO enrollment effort, only 6% exhibited a strong interest while another 12% showed some interest. HMOs are growing most rapidly on the East Coast in the under 40 population.

* * *

Fraud Bill Moves Through House

A bill that would strengthen the government's authority to exclude disciplined physicians from Medicare and Medicaid is moving steadily through the House of Representatives but has not progressed in the Senate.

The bill, HR-1868, was approved unanimously by both the House Ways and Means and Energy and Commerce committees, thus clearing the way for consideration by the full House. The law is aimed at loopholes in the current law which permit a physician who loses a license in one state to treat Medicare and Medicaid patients in another state in which he also holds a license. Current law also does not permit the exclusion from a federal program of a provider who has been barred from another federal program.

HR-1868 would authorize the Department of Health and Human Services to bar from any federal program any provider who: was convicted of abusing program finances, patients, or controlled substances; lost or surrendered his license for cause in any state; provided excessive or poor quality care. If the provider was convicted of a criminal act against Medicare or one of its patients, the minimum period of the exclusion would be five years.

The American Medical Association has supported the aim of the bill but did not support the minimum five-year exclusion and contended that the authority to exclude physicians who provided excessive or poor quality care already exists in the Peer Review Organization law.

Two other bills also were incorporated into HR-1868. One measure that had been opposed by the AMA would allow the Attorney General to revoke the drug prescribing authority of any physician banned from Medicare and Medicaid. The other, which had the general support of the AMA, would authorize civil and monetary penalties against anyone who misrepresents himself as a physician.

Senate Aging Committee chairman John Heinz (R-PA) has introduced similar legislation in the Senate but the bill has yet to be considered in Committee. Meanwhile, the Reagan administration reportedly is developing its own fraud and abuse measure and expects to have it introduced in the Senate.

* * *

AMA Loses Super-PRO Bid

A contract to monitor the work of Medicare's Peer Review Organizations (PROs) will not go to the American Medical Association, which had submitted two bids for the so-called Super-PRO.

Although the contract has not yet been awarded, the AMA was notified that it is no longer in the running for the contract. The letter of notification concluded that the AMA proposal is "not within the competitive range, price and other factors considered."

The notification comes amid rumors that budget cuts within the Health Care Financing Administration have left the agency with less than $2 million for the Super-PRO. It follows an earlier funding problem which forced PRO officials to scale down and reissue their Super-PRO bid request after the AMA and the other three bidders all came in at prices above the $5 million the agency was then reported to have set aside for the winning bidder.

The AMA reportedly was one of 13 bidders in a field that has now been narrowed to two. A selection is expected by about June 10.

The AMA has no immediate comment on the loss of the Super-PRO contract. At a Senate hearing earlier this spring, however, William Felts, M.D., a member of the Association's council on legislation, said that while the contract should go to the AMA, the association would continue to oversee the PROs through its own special monitoring program even if the contract went to another bidder.

* * *

Health Manpower . . . Continued?

Rejecting President Reagan's contention that health manpower programs no longer warrant federal support, the House Commerce Committee last month approved bills extending programs the President proposed to abolish.

The programs include the health professions training assistance, nurse training programs, and the National Health Service Corps reauthorizations which were vetoed by the President last fall and eliminated in his fiscal 1986 budget on grounds that the U.S. already has a surplus of physicians and an adequate supply of nurses.

The committee also approved a bill continuing assistance to community and migrant health centers which the President had proposed to put into a block grant along with black lung disease programs. New federal support of HMOs would be eliminated.

Approved by a convincing 17/6 vote, the health professions bill (HR-2410) in fiscal 1986 would fund physician and other health professionals at their 1985 level of $141 million. Inflation adjustments would be authorized in 1987 and 1988.

Other bills approved by the committee are:

* HR-2418 which authorizes $1.3 billion over the next three fiscal years for community health centers and $167 million for migrant health centers. HMO aid would be phased out as current grants expire.

* HR-2237 which funds the National Health Service Corps field service at $75 million in each of the next three years and provides "such sums as necessary" to award 1175 new scholarships over the next three years.

* HR-2370 which funds nurse training programs at the current level of about $50 million in fiscal 1986. Funds would increase by 5% in 1987 and again in 1988.

* * *

Anti- and Pro-Abortion Campaigns Launched

To counter to the recent wave of anti-abortion publicity, the Planned Parenthood Federation of America has launched a four-stage advertising campaign which defends the rights of women to receive abortion.

Newspaper ads in five major U.S. cities will describe why it is important that abortion remains legal. Headlines will read: "Abortion Is Never The Easy Way Out," "Nine Reasons Why Abortions Are Legal," and "Motherhood Should Be A Joy, Not A Life Sentence."

The full-page ads began appearing in late May in the **New York Times, Washington Post, Chicago Tribune, San Francisco Chronicle,** and **Los Angeles Times.**

An anti-abortion coalition has launched its own publicity campaign called "A Year of Pain and Fear." Specific hospitals, doctors offices, and pharmaceutical manufacturers have been targeted as the site for demonstrations beginning this summer. Magazine ads will follow later in the year, some directly aimed toward various ethnic groups.

Also planned is a publicity event about the 20th anniversary of the U.S. Supreme Court decision in **Griswold v. Connecticut,** which ruled that married couples have a right to use contraceptives.

In the campaign's final stage, Planned Parenthood officials will release a new film that describes the plight of women seeking abortions. It will show the public that most women have abortions for "intensely personal reasons," and are not uncaring, unhuman criminals, Planned Parenthood officials said.

* * *

FDA Delays Salt Labeling on Foods

Under pressure from food manufacturers and supermarkets, the Food and Drug Administration has agreed to postpone mandatory sodium labeling for food packages.

New regulations, which were to have gone into effect by July 1, required that any food labels that list nutritional ingredients must also disclose levels of sodium. The regulations also set criteria for label claims of "very low sodium," "low sodium," "sodium free," "reduced sodium," and "unsalted." An estimated 3,500 companies are subject to regulation.

The regulations are now scheduled to go into effect one year later, on July 1, 1986.

The FDA received 66 requests from food producers and distributors — such as Kraft, Giant Food, Grand Union, Dole, and Castle & Cooke — to delay implementation of the regulation. The companies said they had stockpiles of old labels that needed to be used. The cost of destroying left-over old labels and printing new labels could have been passed onto the consumer, they said.

Consumer groups believe that each extension should be considered on a case-by-case basis, as stated in the original regulations. The FDA, however, believed that an across-the-board extension would be more efficient.

* * *

GME Issue Heating Up in Congress

Newly proposed regulations to freeze Medicare support of direct costs of graduate medical education for a year could prove short-lived if Congress acts on either of two recently-introduced legislative alternatives.

The regulations, which were published in the Federal Register May 21, would implement one of the President's budget proposals and would save an estimated $145 million in fiscal 1986. HCFA proposes a one-year freeze, but requests comments on the advisability of continuing the freeze in future years.

The comment period on the regulations runs until June 20 but the regulation would be implemented on July 1, leaving an extremely tight time frame for assessing and incorporating any comments.

Meanwhile, legislators are moving ahead with their own plans to reform Medicare support of direct medical education costs.

In the Senate, Sens. Robert Dole (R-KS), Dave Durenberger (R-MN) and Lloyd Bentsen (D-TX) have introduced legislation that would freeze these payments for a year, would limit support to five years per student, and eliminate support for foreign medical graduates who are not U.S. citizens.

In the House, Rep. Ralph Regula (R-OH) is sponsoring a plan that would replace the current direct medical education cost pass-through with grants to hospitals. Payments would be capped at $1.015 billion in fiscal 1986 with future increases tied to the increase in the consumer price index.

A formula based on the proportion of residents and Medicare patients at the hospital would be used to determine the payments to individual institutions. Payments would be adjusted for increases of up to 10% in the institution's training program but penalties would be imposed when the increases exceeded 10%.

* * *

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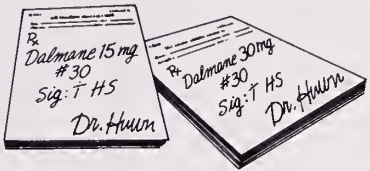

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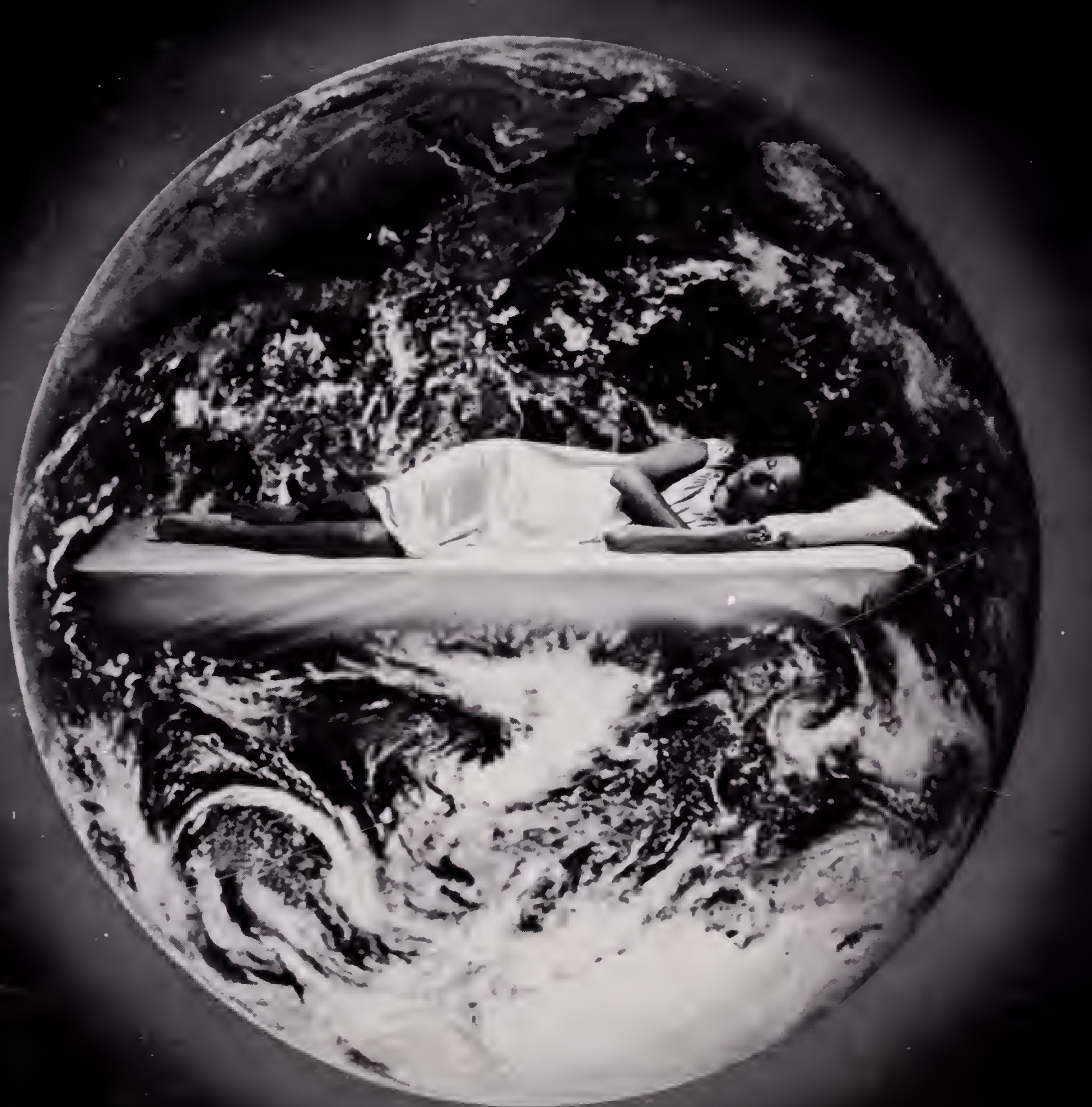

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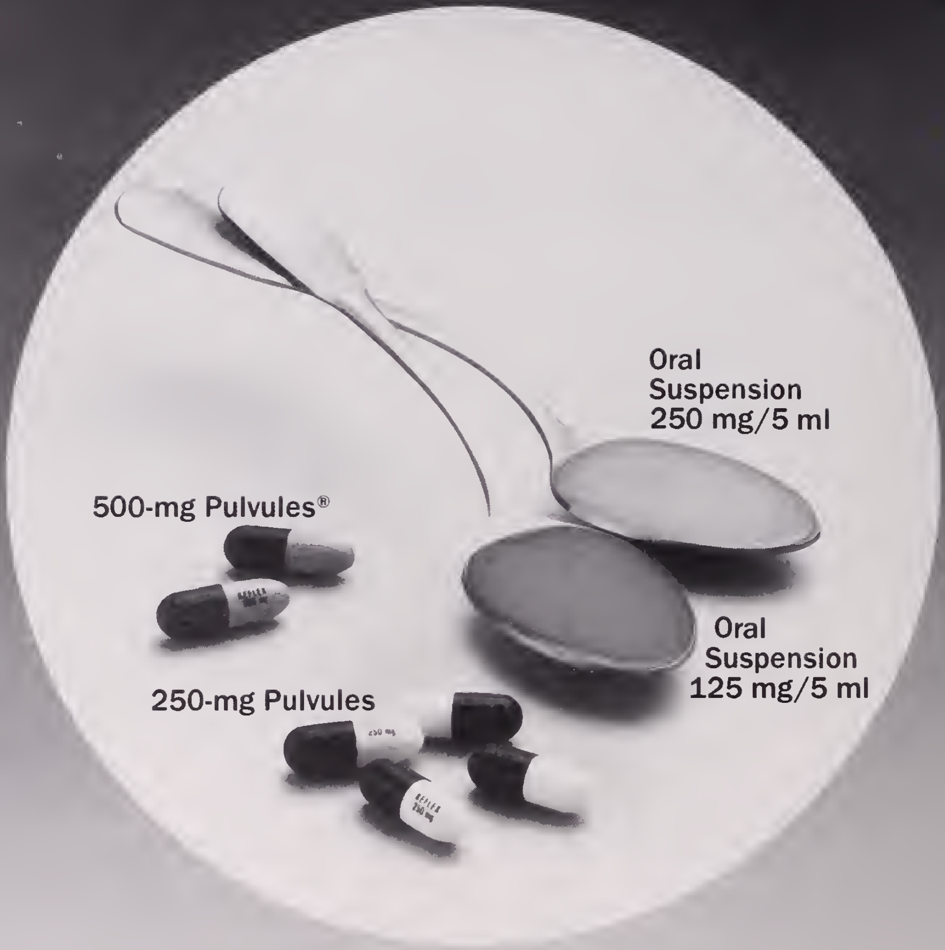

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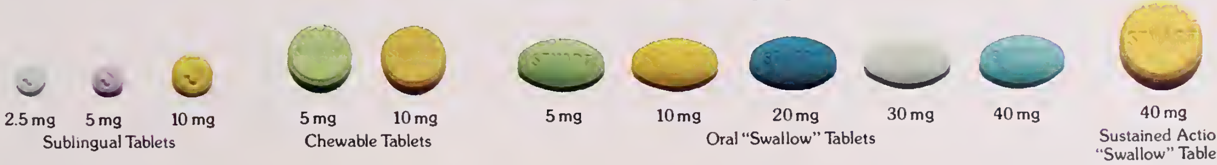

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INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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THE NEBRASKA MEDICAL JOURNAL

Thank You Very Much, Nebraska Medical Association

JERALD R. SCHENKEN, M.D.

ON Wednesday, June 19, 1985, the delegates to the American Medical Association's House of Delegates elected me as a Trustee of the American Medical Association. I was pleased and yet quite humbled at the result of the election for a number of reasons. I was an alternate delegate, the only alternate delegate in the race and possibly the only alternate delegate to win, at least in recent memory. I was from a small state and officially represented a specialty society, the College of American Pathologists. I was most pleased, however, to be given the opportunity to be the candidate of the Nebraska Medical Association (NMA) and the North Central Medical Conference (NCMC), and to have the opportunity to represent physicians of all specialties as I have attempted to do in the past. All of you would have been extremely proud of the team effort, the pride, the dedication, and the commitment of our Nebraska Medical Association delegates as they worked with others in the North Central Medical Conference to bring the campaign to its successful conclusion.

As part of the campaign, I informed the delegates of my objectives if I were to be elected. I phrased them in general terms which would indicate my commitment to all physicians and all patients. Specific issues are often here today and gone tomorrow, but general problems and opportunities remain the same and continue to be a challenge for all of us. I indicated to the delegates that, if elected, I would be dedicated to:

—Preserving a private practice fee for service option for both physicians and patients.

—Defending the dignity of the individual, both patient and physician.

—Fostering the continued growth, effectiveness, credibility, and responsiveness of the American Medical Association to the needs of both patients and physicians.

—Working towards a tax policy that does not impede the free choice of physician by the patient.

—Strengthen the federation's ability to respond to issues and opportunities, no matter where they arise.

In the future, the challenges to organized medicine will be legion. As trustees, we, the physicians responsible for guiding the American Medical Association between meetings of the House of Delegates, will help to cope with them. Without suggesting that problems such as government and corporate intrusion into the practice of medicine, indigent care, AIDS and hepatitis B, the funding of graduate medical education, etc., are in any way less serious to us, I would like to share with you my thoughts about two of our future challenges:

(1) membership, and

(2) leadership — maintaining credibility in competitive times.

The American Medical Association currently has approximately 50 percent of American physicians as members. It is the only organization which acts as an umbrella for all practicing physicians, and it is the only forum in which all aspects of medical care and the needs of all patients may be heard. Within the American Medical Association, the depth and breadth of socioeconomic and/or scientific challenge are great. All aspects of legislative and regulatory impact, public health, science, medical education, etc. are covered. In addition, the AMA provides assistance to states and specialty societies with full gamut of services. Frankly, we would all be getting a bargain if we had to pay two times or even more than the price that we do now. Most of our state and county medical societies would have to double or triple their staffs in order to be even partially as responsive to the needs and concerns of our individual members as they are today. Members of the Nebraska Medical Association can indeed be proud that they were recognized by the House of Delegates in the AMA for having greater than 75 percent of NMA members also being members of the AMA. One of the challenges for the future is to further solidify the profession and consider whether or not unified membership is the way to go. Personally, absent any cogent arguments to the contrary, which I may learn in the future, I am leaning in that direction.

Times are changing and competition among physicians and hospitals is getting more intense by the day. Frankly, however, physicians have been competitive for years. Competitive situations have always existed between rural and urban physicians and institutions, specialists and generalists, and University and private practitioners, etc. Now, unfortunately, we have the added dimension of competition on the basis of price. More than ever before we are in need of leadership within the profession. The challenge of leadership will be to maintain credibility in these competitive times. We must all compete to the patient's benefit; that is, more health services at a reasonable fee, but we must also be joined together on issues of common concern. In this way, we can all both cooperate and compete, and keep the real issues squarely before us rather than try to concern ourselves with such nebulous and divisive concerns as questioning the motivation behind certain actions. This could not have been more clearly demonstrated during the AMA's election process. Among the physicians who worked for my election were a number who have been competing with me and my fellow medical staff members for almost 20 years. We have developed a strong sense of respect for one another and a clear understanding of the difference between competition and cooperation. In many ways, we have been lucky. In our rural state, we have learned lessons that I would hope all our fellow physicians active in organized medicine will learn: compete when you are supposed to compete, and cooperate when you are supposed to cooperate, but always keep the patient's good clearly in mind. This type of leadership will insure that patients will continue to be cared for by physicians who are free to exercise their medical judgment solely on their patient's behalf.

Membership and leadership: we are all in this together!

Nebraska Medical Association and North Central Medical Conference Elect Jerald Schenken to AMA Board of Trustees

ROBERT F. SHAPIRO, M.D.

FOR many of us who attended the AMA annual meeting in Chicago, June 15-20, 1985, the highlight was seeing Jerald R. Schenken elected to the AMA Board of Trustees. Never in the long history of the AMA has Nebraska seen one of its members elected as a trustee. All of us stand to benefit by having an influential voice in the highest council of this most democratic of organizations which effectively represents a large proportion of American physicians of all specialties and practice arrangements.

Dr. Alan Forker, Editor, asked me to write an article to reflect the background, excitement and effort which goes into electing a trustee.

To use a "cooking" metaphor, it takes the proper ingredients, temperature and time to make the "recipe" come out just right. The time, effort, talent and resources which go into an AMA election, at least in my limited experience, are mind boggling and rivals a campaign for the Congress or the Senate but on a smaller scale.

The most important part of the recipe is your candidate. The candidates for offices and commissions of the AMA in terms of quality and personal attributes are some of the best people you could ever hope to meet. Most are hard working, strong and dedicated to our profession. Their campaigns for these offices are exhausting; the job will place great demands on them if elected.

People are going to invest time, effort and money in the campaign; therefore, they want to back a person with energy and staying power. These individuals will be representing a large and significant share of the American physician population. It is preferable that they be intelligent, knowledgeable, interested, articulate, adaptable, and above all, presentable.

Our candidate had all the ingredients. Jerry Schenken is a hard working physician, a pathologist from Omaha. He has a long interest and background in organized medicine. He is active in teaching at both Omaha Medical Schools and knows the concerns of the upcoming generation of physicians. He is active at the Methodist Hospital and in the Metropolitan Omaha Medical Society. He is a delegate to the Nebraska Medical Association and serves on the NEBPAC Board and NMA Commissions. He serves on the American Board of Pathology presently as its chairman. He was legislative chairman for the College of American Pathology and found his way to the AMA as an alternate delegate from that organization. This is only a brief and incomplete account of his activities but demonstrates that he has "gone through the chairs." He is not merely a joiner but rather an active worker helping organizations to forge and meet their objectives. I would categorically state that he was one of the top two or three candidates running for the AMA Board of Trustees.

That having been said, it must be noted that many good or even excellent candidates do not get elected to office. To go further in our cooking metaphor, the temperature i.e. "environment" must also be right. The North Central Medical Conference of which we are a part (North Dakota, South Dakota, Iowa, Wisconsin, Minnesota and Nebraska) did not have a member on the Board of Trustees. Geographically, the closest trustee was Hugh Ritter, M.D., Secretary-Treasurer from St. Louis, who was leaving the Board of Trustees because he had completed his eligibility.

Functionally, the AMA appears to have a

heavy future agenda of legislative involvement. This is Jerry Schenken's strength since he served as chairman of the AMA's legislative council.

Jerry's father, John R. (Rudy) Schenken, had long been active in the AMA and many of his long time friends were still active delegates.

The CAP-NMA and North Central Medical Conference were all willing to back Jerry as a concensus candidate and everyone was committed to working hard. Candidates backed only by a small state or a medical specialty society ordinarily will not do well regardless of ability.

There were four full three-year openings on the Board of Trustees plus the fifth unexpired term created by the elevation of Dr. Todd from New Jersey to Chief Deputy Executive Director of the AMA under Dr. James Sammons. There were a total of ten candidates.

So at this point it was determined that the environment (temperature) was right.

The campaign itself represents "cooking the meal". Dr. Schenken selected Dr. Jack Coe, a surgeon from Omaha, as his Campaign Manager. He could not have selected better. Jack was a tireless and enthusiastic worker.

Realistically, the campaign began months before the annual meeting in June in Chicago. Dr. Schenken spearheaded the activity. Having the CAP-NMA and NCMC working on his behalf provided many spear carriers. The Omaha doctors provided yeoman service contacting fellow physicians in their specialties who were delegates or alternate delegates to the AMA. Letters were written on Jerry's behalf and many phone calls were made. A bibliographic brochure was prepared and distributed.

Working with the people from the NMA and NCMC and the financial resources available, some "giveaways" were selected for the Chicago meeting. A properly labeled flashlight, a pin, and a shopping bag to carry the delegates workbook were obtained and taken to Chicago. A drawing was to be held for some Nebraska steaks and popcorn.

The NMA and North Central Conferences agreed to sponsor a nightly hospitality suite and to have a Monday night party in one of the hotel's party rooms. How many votes this actually generated is conjectural but you do have to be in the "game".

Several of us worked as "carnival barkers" to bring passersby into the suite and this helped to create the atmosphere of great support for our candidate.

Probably one of the most significant activities relates to the fact that other states organize themselves as coalitions similar to the North Central Medical Conference, unless they are large enough to consider themselves relatively autonomous. All of these coalitions have candidate evaluation committees where the candidate may present his "platform" and respond to questions. This is a great opportunity to present yourself at your best or your worst.

To be successful, you need to know who you are and what the job you are campaigning for is all about and why you are the person who should be among those selected.

Dr. Schenken's strategy was to present himself as a "problem solver". Knowing full well that problems change and circumstances change so that there are no "pat" answers, he presented himself as a person able to evaluate, analyze, and deal effectively with the problems whatever they might be.

From all the feedback we were able to obtain, it appeared that this approach as well as all the personal factors were favorable to our candidate. When the election was held on Wednesday morning, Dr. Schenken, an alternate delegate to the AMA from Nebraska, was selected on the first ballot.

Use of Intestinal Segments in Urology

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URINARY tract refunctionalization has been established during the past decade as a successful form of surgical treatment for the sequelae of urinary diversion. As indications for diversion have become extremely limited, efforts have been redirected toward urinary tract reconstruction. Contraindications to undiversion have now, in like manner, become almost nil.[1]

Materials and Methods

Six patients were selected after careful history, physical examination, and diligent evaluation of their previous medical records to ascertain: (1) the indications for initial urinary diversion, (2) the preservation or deterioration of renal function after diversion, (3) the occurrence of clinical infections and urolithiasis; (4) appliance adaptation and function. Preoperative studies included assessment of renal function, radiologic imaging of the urinary system, urodynamic studies of the lower urinary tract, cystoscopic examination of the bladder and urethra, and an assessment of the social and psychological effects of urinary diversion.

Case Reports

Patient #1: A 27 year old male with a solitary kidney and ileal conduit presented with acute pyelonephritis and obstruction at the ureteropelvic junction by a calculus. He responded well to percutaneous decompression, antibiotic therapy, and chemolysis of the obstructing calculus.

The patient had suffered repeated episodes of chronic pyelonephritis, requiring left nephrectomy and ileal conduit diversion at eight years of age after several unsuccessful surgical attempts to relieve his ureterovescial junction obstruction. Following diversion, he did well until 14 years of age when he began to have recurrent bouts of pyelonephritis with nephrolithiasis, requiring repeated hospitalizations.

When seen by us, his serum creatinine was 2.1 mg % and his creatinine clearance was 44 ml/min. An intravenous pyelogram (IVP) showed marked hydronephrosis with rapid renal concentration and excretion. Ultrasound confirmed the above and was obtained as a baseline for further comparison. Bladder function studies revealed essentially normal storage and voiding function, with good urinary control. Cystoscopically, he was noted to have a widely patent urethra with normal internal anatomical bladder configuration and mucosa.

He underwent a ureteroileovesicostomy with tapering of the ileum and the creation of a long submucosal tunnel to prevent reflux (Fig. 1). His postoperative course was uneventful; at twelve months followup, his serum creatinine was 1.9 mg %. He was continent, while his voiding volumes were over 300 cc's with minimal bladder residual. He has remained clinically free of infection, there has been no recurrence of renal calculi, and there has been marked reduction in hydronephrosis.

Patient #2: A 27 year old female with an ileal conduit presented with recurrent pyelonephritis and nephrolithiasis. Persistent ureteral reflux necessitated the construction of an ileal conduit at eight years of age, after two unsuccessful attempts at ureteral reimplantation.

Since diversion, the patient has been hospitalized at least once per year with recurrent urinary tract infection and stone formation. She underwent surgical removal of a right staghorn calculus in 1978, and also underwent

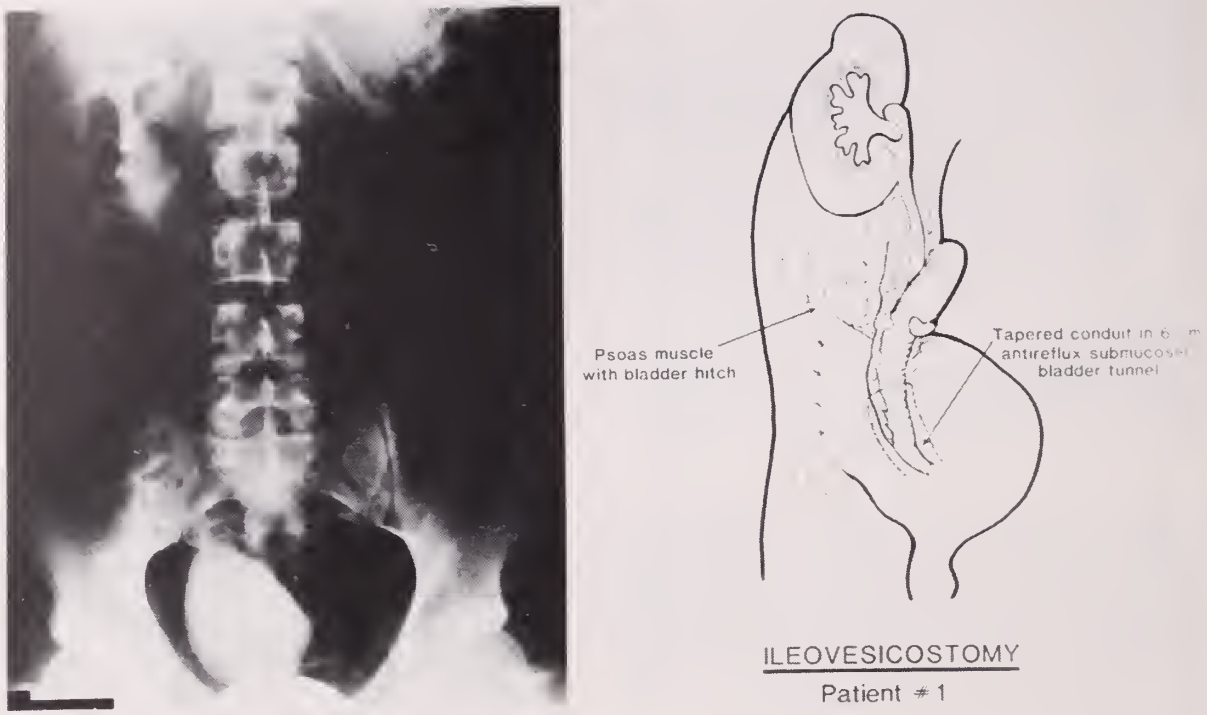

Figure 1
Left: Intravenous pyelogram showing preservation of solitary kidney. Right: Diagrammatic drawing of operation.

bilateral coagulum pyelolithotomy for removal of triple phosphate calculi in 1981 and 1982.

Her creatinine was 2.1 mg %; an IVP demonstrated bilateral hydronephrosis with prompt appearance of the contrast through a well-functioning conduit. Baseline ultrasonography confirmed marked hydronephrosis. Urodynamic studies revealed a compliant, stable bladder with adequate capacity, excellent continence and complete emptying.

She underwent an ileovesicostomy with tapering and an antireflux anastomosis between bladder and ileum. In order to accomplish this, the length of ileum needed to be augmented with an additional segment of ileum (Fig. 2).

Twelve months postoperatively, her serum creatinine was 1.7 mg%. She was entirely continent of urine with a volume averaging 150 to 200 cc's. Ultrasonography depicted a diminution of hydronephrosis and a voiding cystourethrogram (VCU) demonstrated complete bladder emptying and low grade ureteral reflux only after high pressure filling. Her urine cultures have intermittently demonstrated asymptomatic bacterial colonization.

Patient #3 is a 14 year old male with Prune belly syndrome who had undergone removal of a nonfunctioning left kidney in 1973, and construction of a right pyeloileal conduit in 1974 for treatment of progressive right hydronephrosis and deteriorating renal function. Studies after diversion identified a persistent decline in creatinine clearance.

His serum creatinine was 1.1 mg % with a creatinine clearance of 37 ml/min. IVP showed progressive hydronephrosis, confirmed with baseline ultrasound. Urodynamic studies revealed a compliant, stable, but small capacity bladder. Cyclic bladder training improved his bladder capacity from 100 to 275 cc's.

He underwent ileovesicostomy with nippling of the ileum into the bladder as an anti-reflux mechanism (Fig. 3). At 6 months followup, his serum creatinine and BUN were 0.9 mg% and 20 mg%., with radiographic evidence of a mild improvement of his hydronephrosis. He was completely continent with voiding volumes of over 200 cc's and small postvoid residuals. Vesicoureteral reflux was demonstrated on VCU only after bladder fillings in excess of 500 cc's. Urine cultures have remained negative. He was recently placed on intermittent catheterization as he was not emptying his bladder.

Patient #4: A 7 year old myelodysplastic patient with neurogenic bladder was diverted with a transureteroureterocutaneous ureterostomy for treatment of progressive hydronephrosis at 6 months of age. Recurrent pyelonephritis had required six hospitalizations during the past four years in spite of suppressive antibiotic therapy.

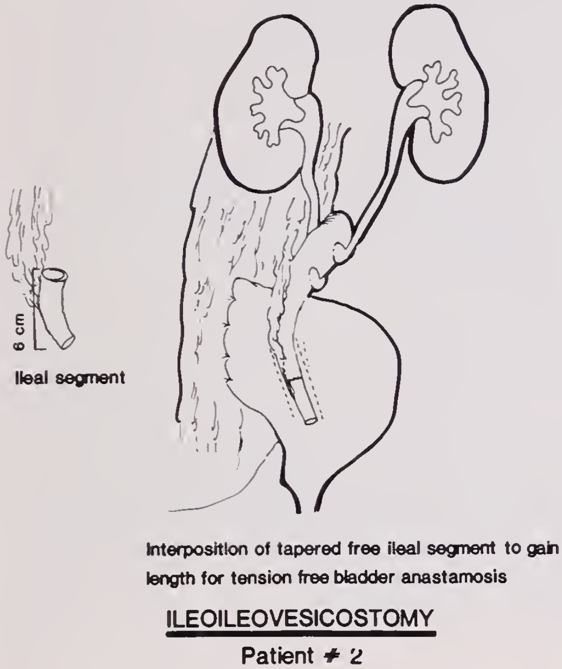
6 cm
Ileal segment
Interposition of tapered free ileal segment to gain length for tension free bladder anastamosis
ILEOILEOVESICOSTOMY
Patient # 2

Figure 2
Diagram of operation of patient number 2.

Preoperatively, his serum creatinine was 0.5 mg% with a creatinine clearance of 90 cc/min. IVP, ultrasonography, and retrograde studies demonstrated bilateral hydronephrosis with narrowing of the distal right ureter and delayed right-sided emptying. Bladder function studies revealed a small capacity, but stable bladder, which achieved only a 70 cc capacity after a four week course of hydrostatic bladder stretching. He was continent with bladder filling.

As a very alert and active boy, with highly motivated parents, we felt confident that intermittent catheterization would responsibly be performed if necessary. He underwent an ureteroneocystostomy with transureteroureterostomy and a sigmoid patch augmentation cystoplasty (Fig. 4). His bladder capacity was measured in excess of 200 cc's during the second postoperative week and should progressively increase with normal bladder filling.

Patient #5: Intestinal appendix used for continent stoma (Mitrafanoff Procedure).

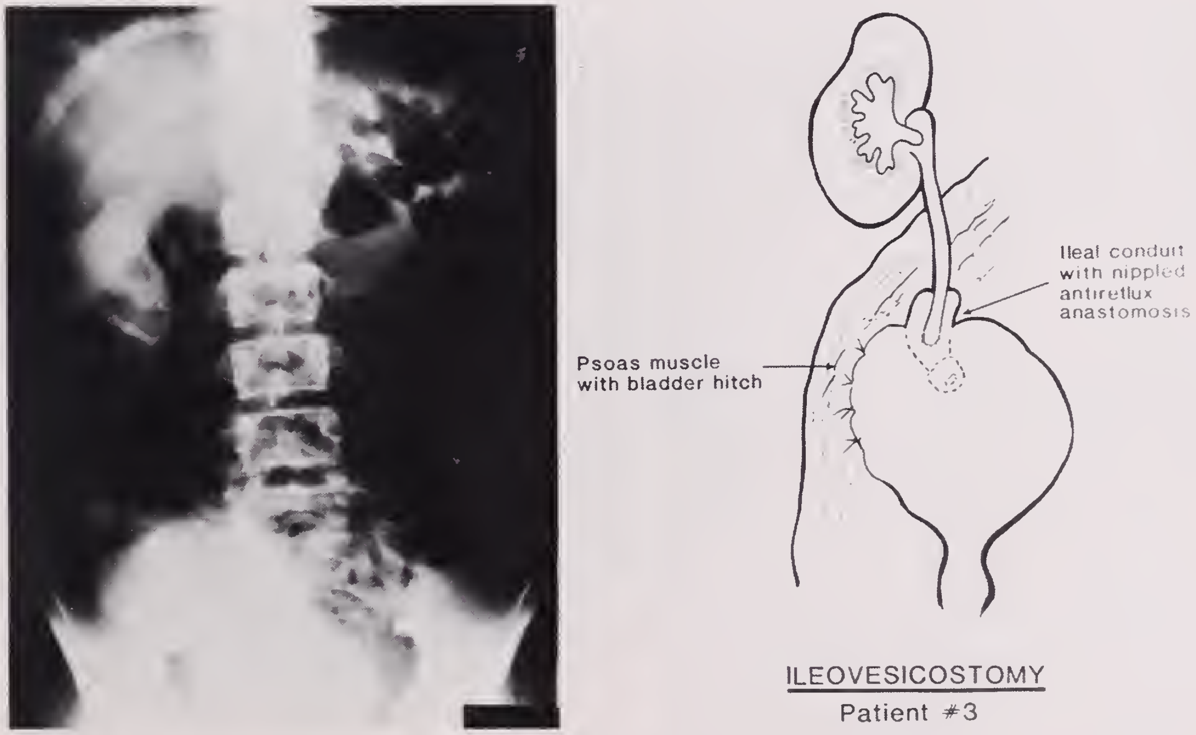
Ileal conduit with nippled antireflux anastomosis
Psoas muscle with bladder hitch
ILEOVESICOSTOMY
Patient #3

Figure 3
Left: IVP postoperative. Right: Diagram of operative procedure.

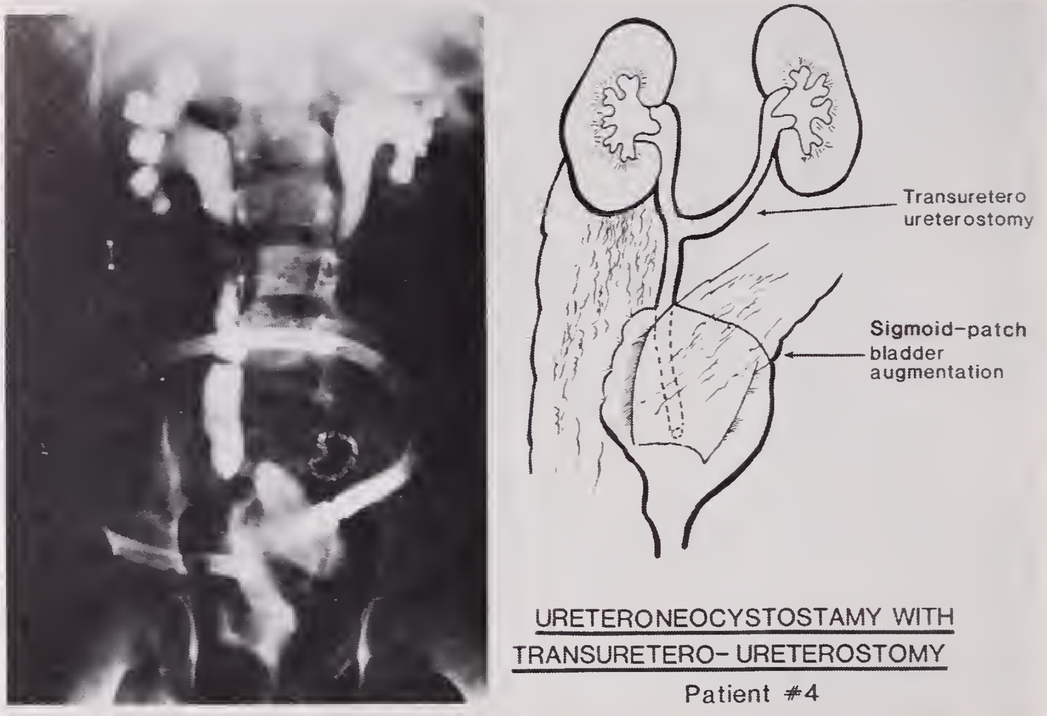
Transuretero ureterostomy
Sigmoid–patch bladder augmentation
URETERONEOCYSTOSTAMY WITH TRANSURETERO– URETEROSTOMY
Patient #4

Figure 4
Left: IVP postoperatively. Right: Diagram of operation.

A 22 year old male with Down's Syndrome, a neurogenic bladder and subsequent urinary retention, obstructive nephropathy, and recurrent urinary tract infections was referred for care. Pharmacotherapy failed to improve bladder emptying; attempts at intermittent urethral catheterization made this otherwise pleasant young man very combative. Indwelling urethral catheters and suprapubic cystostomy met with recurrent urinary tract infection and abdominal wall cellulitis, respectively.

The patient tolerated manipulation of his suprapubic cystostomy and, as he was continent of urine with a large capacity bladder, we felt that he would be an ideal candidate for intermittent catheterization through a continent stoma of the appendix.

Preoperatively, his serum creatinine was 2 mg% with a creatinine clearance of 45 cc/min. Ultrasonography and retrograde studies demonstrated mild hydronephrosis, changes of previous right pyeloplasty and a thoracic left kidney. Urodynamic studies identified a large post void residual secondary to external and internal sphincter dyssynergia. Cystoscopically, his urethra and bladder neck were widely patent and no vesico-ureteral reflux was observed with cystography.

He underwent construction of a continent stoma with the appendix (Fig. 5). The appendix and its blood supply were separated from the cecum, and the opened, distal end of the appendix was anastomosed to the anterior bladder wall in a long submucosal tunnel. The proximal appendix was externalized for construction of the skin stoma.

Postoperatively, he was successfully intermittently catheterized through his appendiceal stoma four times daily. There was no leakage of urine from the stoma in between catheterizations. He remained entirely continent and free of infection.

Patient #6: A 14 year old male spina bifida patient was referred because of incontinence and bladder-bowel dysfunction. The patient was an otherwise remarkably well developed, active patient. His dribbling incontinence was corrected by placing an artificial sphincter in 1982, and his mild bladder instability was controlled with anticholinergic medication. Neuropathic bladder dysfunction proved re-

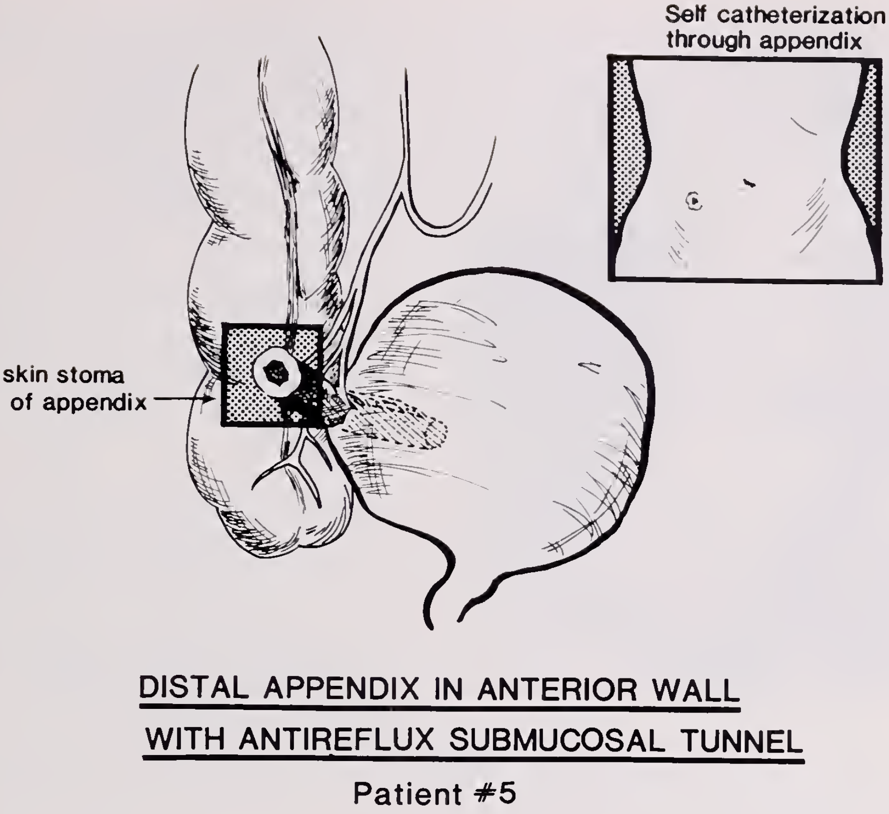
Self catheterization through appendix
skin stoma of appendix
DISTAL APPENDIX IN ANTERIOR WALL WITH ANTIREFLUX SUBMUCOSAL TUNNEL
Patient #5

Figure 5
Diagram of operation.

fractory to long term pharmacologic therapy; high pressure vesical instability jeopardized his renal function in spite of intermittent catheterization. A subtotal cystectomy with augumentation sigmoid cystoplasty was performed in December, 1983. This improved his bladder capacity, but high-storage pressure and incontinence later reappeared with the regeneration of sigmoid peristalsis. A patch of ileum was placed in August 1984 to interrupt the sigmoid intramural plexus, thus reducing bladder pressure and augmenting capacity (Fig. 6).

The patient is presently entirely continent of urine during the daytime, experiencing only minimal nocturnal enuresis. His renal function has remained stable with a creatinine of 2.2 mg% and ultrasonography demonstrates improvement of the hydronephrosis. He is intermittently catheterizing himself 4-5 times a day to insure bladder emptying.

Discussion

These patients represent our initial experience in undiversion at the University of Nebraska Medical Center. Based upon these gratifying results, several other candidates are now under consideration for similar procedures. These patients have been psychologically and socially uplifted by the removal of the urinary collecting devices that they have worn on their abdomens since childhood. Their renal function has been preserved and they have been free of recurrent episodes of pyelonephritis.

Urinary diversion was previously considered the safest form of treatment for the preservation of renal function in complex cases of obstructive uropathy and massive vesicoureteral reflux, and at times, was indeed life saving. Temporary diversion, utilized in patients who were either too young or too ill for definitive reconstruction, was achieved with nephrostomy, loop pyelostomy, ureterostomy, cutaneous vesicostomy, or suprapubic cystostomy. Permanent diversion was utilized when attmepts at reconstruction were unsuccessful, or where reconstruction was technically not feasible or unsafe in patients with precarious

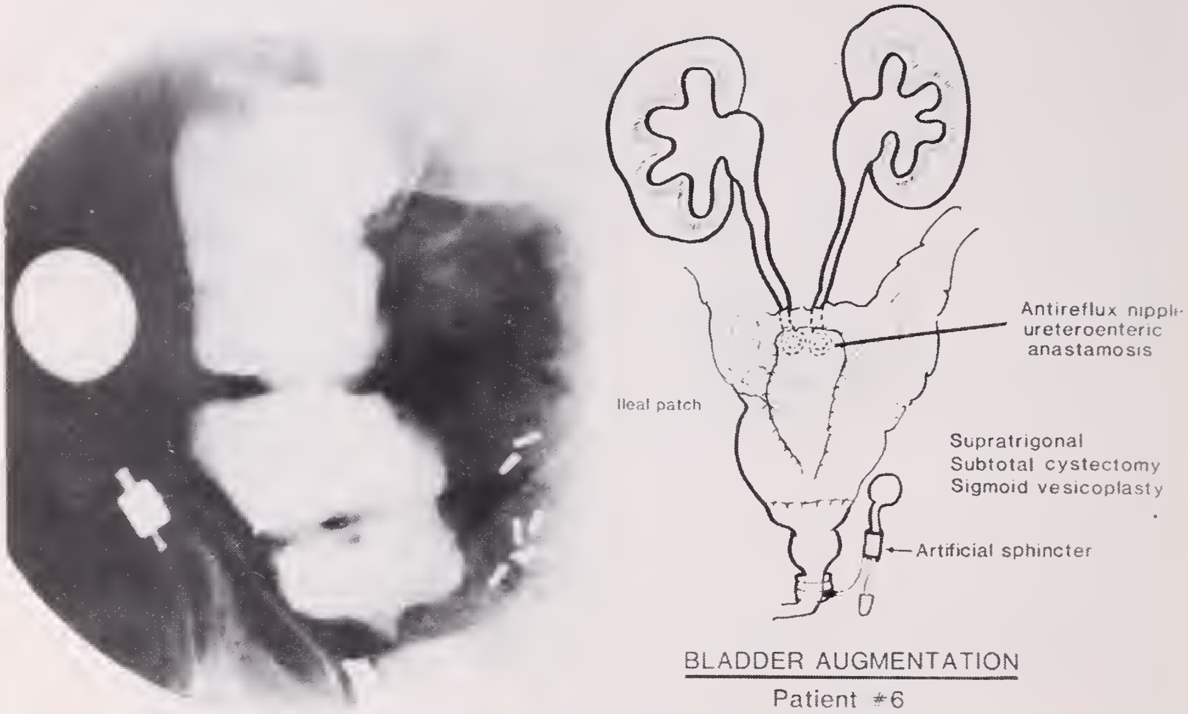

Figure 6
Left: IVP of final postoperative result. Right: Diagram of final operation.

renal function. These methods included: Ileal or colonic conduit, skin ureterostomy, and tubeless cystostomy. These operations initially worked quite well in protecting against rapid deterioration of renal function, but the long term sequaelae are now assessed: calculus formation, low grade persistent bacilluria, deterioration of renal function, stomal complications, and the psychosocial effects of a stoma.

The first major series of undiversion was described by Dr. Hendren, approximately ten years ago.[1] Subsequent reports detailing the procedure and its follow-up have confirmed the success of the techniques and principals that he described.

The method of undiversion varies in response to the anatomical construction of the initial diversion and the underlying disorder that necessitated it. Various procedures have been devised: ureteroneocystostomy, transureteroureterostomy, ileocystostomy, ileoureterostomy, and ileoileocystostomy. Success in these procedures depends upon meticulous technique, avoiding anastomotic leaks, angulation and reflux, and requires preservation of every centimeter of available ureter and conduit for anastomosis to the bladder. Lengthening maneuvers can be achieved by interposition of a free loop of bowel, partial incision of conduit mesentery, fixation and elevation of the bladder with a psoas hitch, and construction of a Boari flap.[1]

The majority of small dysfunctionalized bladders can be restored to stable, low pressure, large capacity storage vessels by hydrostatic sequential bladder stretching, via suprapubic or urethral catheter. Indistensible small fibrotic bladders, or those with hyperreflexia refractory to anticholinergic medications should be augmented with bowel. Subtotal cystectomy prior to enterocystoplasty, or bivalving the bladder is at times necessary in cases of severe hyperreflexia. Total bowel replacement of bladder in previously cystectomized patients has been successfully performed in some urologic centers since 1981. Many of these patients demonstrate excellent storage. Bladder emptying is accomplished by intermittent catheterization.[2]

If incontinence persists after undiversion, it can be corrected with the Scott artificial sphincter.[3]

Successful undiversion or primary urinary tract reconstruction requires extensive preoperative evaluation and meticulously performed surgery. The patient should be referred to Centers where modern radiographic equipment and sophisticated urodynamic lab testing are available. The surgeon must possess skills that allow him to perform any alternate procedures that may become indicated intraoperatively. His surgical armamentarium must include experience in artificial sphincter insertion, continent stoma construction, antirefluxing internal diversion, and multiple bladder augmentation procedures.

Summary

Modern surgical techniques and a broader understanding of the management and pathophysiology of congenital obstructive uropathy has virtually eliminated the need for permanent urinary diversion in cases where the bladder can be preserved. Patients who have previously been diverted are now being undiverted. No child should have a draining urinary stoma if they can reliabley be intermittently catheterized.

Six patients have been successfully undiverted, or spared urinary diversion during the past twenty-two months at the University of Nebraska Medical Center. Early results have shown: (1) Preservation of previously deteriorating renal function; (2) The ability to maintain sterile urine; (3) Elimination of recurrent nephrolithiasis and pyelonephritis; (4) Social and psychological benefits.

Addendum:

We have employed the use of intestinal segments in urinary tract reconstruction or undiversion in 6 additional patients since completion of this paper. Kock pouch internal diversion with a continent stoma was successfully constructed in three of these patients.

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Voice Restoration Following Total Laryngectomy

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THE loss of the ability to communicate following total laryngectomy has serious social and economic consequences. The aphonic patient may become reclusive and depressed; a once productive individual may become unemployable and unable to manage his own affairs. Almost 3,000 total laryngectomies are performed each year, the majority for squamous cell cancer of the larynx.

Laryngeal cancer in its early stages is amenable to conservation surgery, i.e., the adequate removal of cancer while preserving the sphincteric, respiratory and phonatory function of the larynx; however, many tumors can be treated successfully only with total laryngectomy. This is especially true after radiation therapy failure. Procedures which retain the larynx, but go beyond the usual limitations of conservation surgery have had an unacceptable recurrance rate and/or an increase in the incidence of complications. Total laryngectomy remains an effective operation for local control of cancer; however, the potential sequelae of the procedure leave much to be desired. Ideally, these patients can learn to use esophageal speech, but only 20-70% of candidates can ever master this skill, even with intensive speech therapy. The electrolarynx has an objectionable speech quality and is not physiologic.

History

The importance of early speech rehabilitation has been recognized for over 100 years. Soon after Billroth performed the first successful total laryngectomy in 1874, attempts were being made to devise methods of restoring speech. It was discovered early that speech could be produced by establishing a communication between the trachea and the esophagus or hypopharynx. With this idea in mind, one of Billroth's residents, Gussenbauer, devised a tracheostomy tube which was modified with an extension into the pharynx.[1] Many other ingenious attempts have been made at establishing a tracheoesophageal fistual for speech production; however, they have all been complicated by aspiration, stenosis or leakage around the prosthesis. Many of these patients have had radiation therapy and radical neck dissection, and major surgical procedures designed for voice restoration are fraught with morbidity.

In 1959, Dr. John Conley constructed a tracheoesophageal shunt using a vein graft.[2] Asai in Japan and Miller in the United States devised a three-stage procedure which established a subcutaneous skin-lined tube from the trachea to the oral cavity.[3,4] In 1971, Calcaterra described an inferiorly based esophageal mucosal flap to construct a tracheoesophageal shunt.[5,6] Ogura was the first American to attempt the reconstruction of a pseudoglottis after a laryngectomy. He used various muscle flaps to create a functional pretracheal sphincter (valve); however, he abandoned this procedure because of the problems of aspiration and decanulation.[7] Over ten years later in Europe, Staffieri[8] and Serafini[9] developed their own variations of the technique of pseudoglottic reconstruction. All of the aforementioned procedures were plagued by either stenosis, aspiration, or surgical complexity. Replantation and/or transplantation of the canine larynx were attempted by several groups including Ogura,[10] Som[11] and Boles,[12] but the multiple problems were never resolved. In

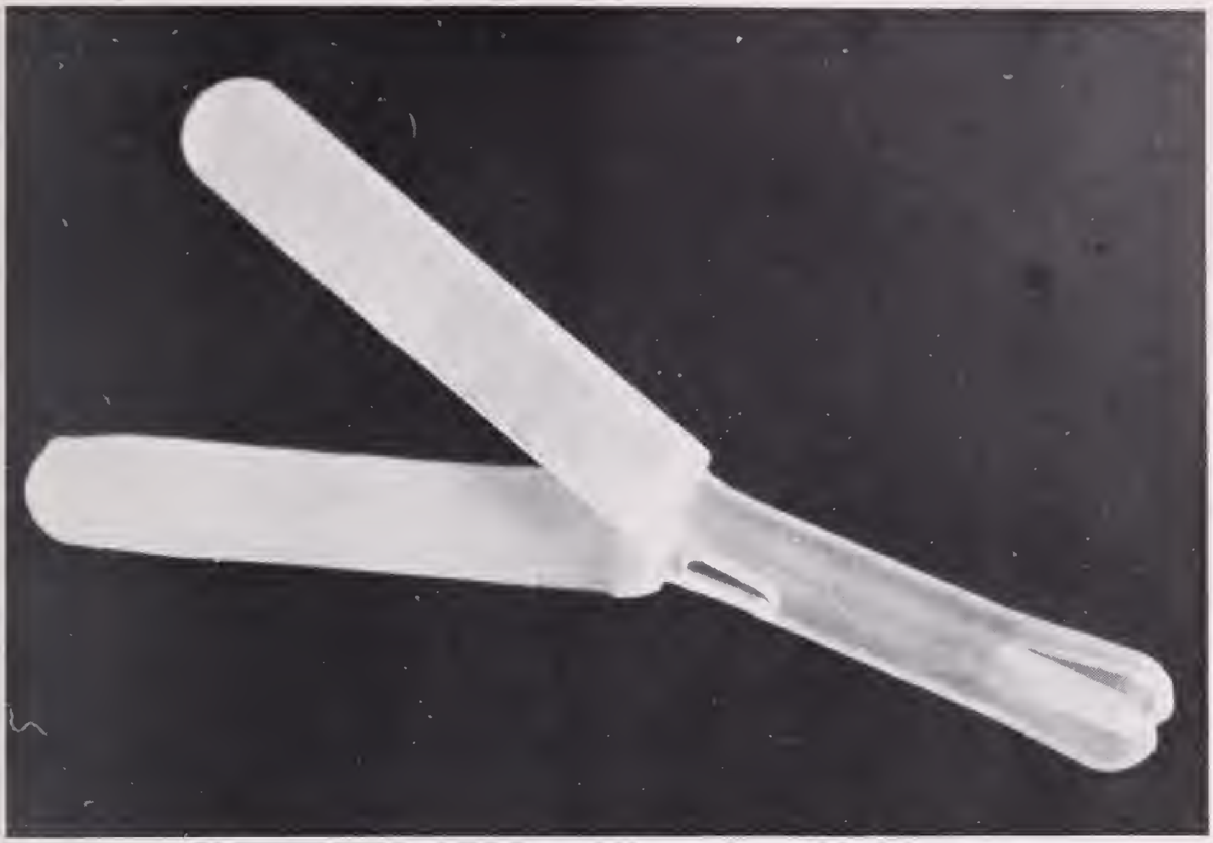

Figure 1

the last 100 years, there have been many ingenious attempts at establishing a one-way connection between the trachea and the esophagus following laryngectomy, but none have gained universal acceptance.

In 1980, Mark Singer, M.D., and Eric Blom, Ph.D., reported a silastic one-way valve prosthesis which was placed in an endoscopically produced endotracheoesophageal fistula. Their method of voice restoration was simple, reproducible by other otolaryngologists, and avoided the complications of aspiration and stenosis. They reported a success rate of over 90% in restoring speech with few complications.[13] This original prosthesis has since been improved in several respects, and is manufactured by Bivona Surgical Instruments. Other similar devices include the Panje voice button by Xomed; and the American V. Mueller Blom-Singer voice prosthesis.

Technique

The surgical technique consists of the creation of a tracheoesophageal puncture under endoscopic control performed under a general anesthetic. An obturator consisting of a #14 Fr. red rubber catheter is kept in the fistual for two days. The voice prosthesis is then substituted for the obturator in a clinic setting. The procedure is short, simple and can even be done as outpatient surgery. It is relatively painless, and the patient can resume his normal activities within days after the procedure. Voice production is possible as soon as the prosthesis is fitted, but speech therapy is still required in order to optimize speech results. The tracheoesophageal fistula puncture can also be done at the time of the total laryngectomy in selected patients.

The voice prosthesis is made of silicone and functions as a one-way valve (Figure 1). The valve is closed during resting conditions and swallowing, preventing aspiration. When positive pressure develops in the trachea, air flows through the valve into the esophagus producing speech. The biggest disadvantage of the original prosthesis was that it required the patient to occlude the stoma with his hand in order to create positive pressure in the tracheobronchial tree. The latest voice restoration systems have a special tracheostomal valve which when used in conjunction with the voice prosthesis eliminates the need for finger closure[14] (Figure 2). This pressure sensitive valve, which fits into the patient's stoma, is separate from the voice prosthesis. It closes during speech, reflecting air back through the voice prosthesis and into the esophagus (Figure 3). The newest voice prostheses also have a lower opening pressure which should improve the success rate.[14,15] The original voice prosthesis required daily removal for cleaning and special taping procedures, but the newer prostheses are self-retaining and do not need daily cleaning.

Results

In the original series by Singer and Blom, 90% of the total laryngectomy patients were able to learn acceptable speech with their voice prosthesis.[13] More recent reports from these authors and others have achieved comparable results.[16,17] It is important to note that these studies included patients who failed at traditional esophageal speech. Radiation therapy and radical neck dissection do not seem to be a contraindication for the surgical placement of a voice prosthesis.[13]

The speech with the voice prosthesis is louder, more forceful and allows longer phrases than with esophageal speech. The speech is more fluent and understandable because of the longer phrasing. Use of the prosthesis requires less effort than esophageal speech and eliminates the audible air gulping characteristic of esophageal speech. In addition, the acoustic characteristics of speech with the voice prosthesis are more similar to laryngeal speech than esophageal speech.[18]

Currently, any patient who has undergone a total laryngectomy and is free of tumor is a candidate for this procedure. Patients should have good manual dexterity, fair vision, and be well-motivated and willing to care for the prosthesis themselves. It is important that the patient himself is motivated and not just his family. The only physical constraint is that the tracheostoma must be of adequate size to

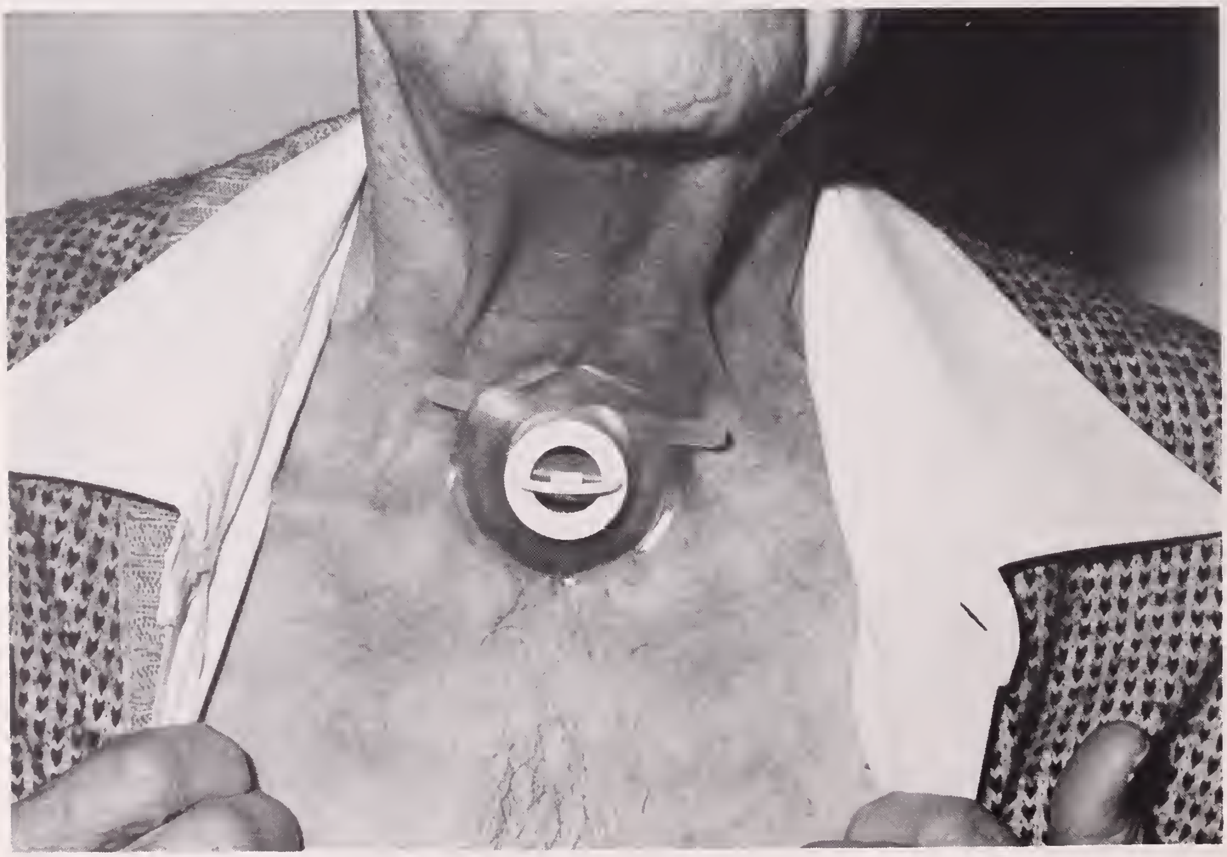

Figure 2

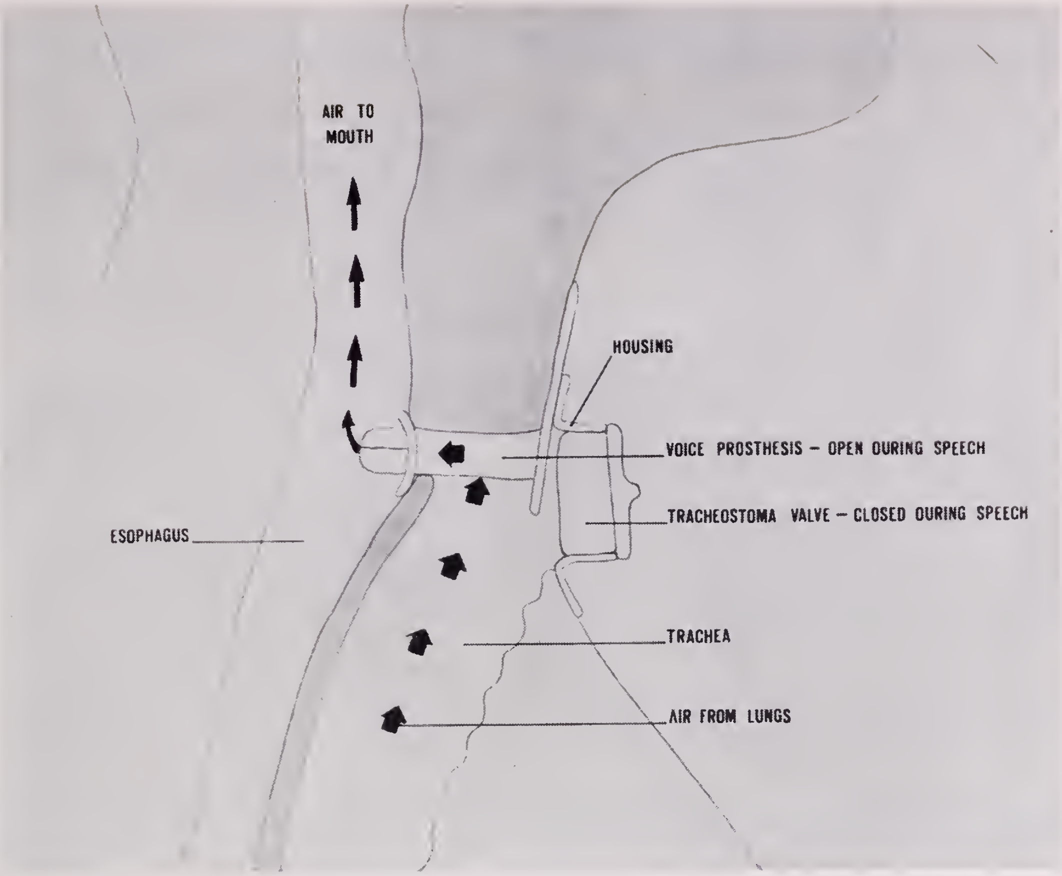
AIR TO MOUTH
HOUSING
VOICE PROSTHESIS – OPEN DURING SPEECH
TRACHEOSTOMA VALVE – CLOSED DURING SPEECH
ESOPHAGUS
TRACHEA
AIR FROM LUNGS

Figure 3

accomodate the prosthesis without impeding respirations. If it is too small in diameter, it can be dilated to a larger size.

Complications have been minimal.[13,16,17] If the patient does not like the prosthesis, or if it is unsuccessful, it can be removed easily, and in most cases, the fistula will close spontaneously. In some patients, leakage of saliva around the prosthesis has occurred, but repeated cauterization of the fistula has usually solved the problem. In patients who were unable to generate speech with the voice prosthesis, Singer and Blom have found that pharyngoesophageal spasm was the problem, and a cricopharyngeal myotomy helped the majority of these failures.[19] A preoperative esophageal air insufflation test may help to identify these patients and a parapharyngeal nerve block will confirm the source of the problem.

Summary

New methods of voice restoration are simple, effective, and carry little morbidity. These voice prostheses have many advantages over prior methods of voice restoration. There is little morbidity, and it has proven itself cost-effective. Speech rehabilitation is rapid, and it avoids the serious problems associated with prior surgical procedures including aspiration and stenosis. The procedure is also reversible. The speech produced with the voice prosthesis is superior to esophageal speech in several respects. These recent advances in voice restoration should be beneficial to those patients who are motivated to learn speech and resume a normal life.

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Diuretic-Induced Hypokalemia: A Possible Cause of Out-of-Hospital Cardiac Arrest

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THE most common electrolyte abnormality encountered in clinical practice, hypokalemia, occurs in 23% to 40% of patients treated with thiazide diuretics and poses a hazard for millions of people.[1-5] Morgan and Davidson[6] evaluated publications through 1979 and found an average fall in serum potassium concentrations of 0.69mEq/L in hypertensive patients treated with thiazides or chlorthalidone. From their analysis, they concluded that the frequency of hypokalemia and diuretic therapy for hypertension would approximate 48% if a serum potassium concentration of less than 3.5mEq/L was used as a criteria for hypokalemia or 17% if 3.0mEq/L was used.

Hypokalemia has long been incriminated as a trigger for ventricular fibrillation (VF) in both experimental animal models and patients with underlying heart disease.[2,7-9] Ventricular fibrillation is attributed to repetitive excitation of cardiac tissue by re-entry, or to enhanced automaticity of latent pacemaker sites, processes that may be present in both hypokalemia and myocardial ischemia.[2] Coexistence of these two conditions may precipitate ventricular dysrhythmias. Thompson and Cobb[10] recently reported that hypokalemia is present in half the survivors of out-of-hospital cardiac arrest due to VF. Diuretic administration did not appear to account for the hypokalemia. The authors concluded that hypokalemia following out-of-hospital arrest was due to an intracellular potassium shift induced by metabolic events during resuscitation. Unfortunately, Thompson's study lacked information about whether or not patients receiving diuretics were also on potassium supplementation and the total body deficit of potassium was unknown.

We report a patient admitted to the intensive care unit following successful resuscitation from out-of-hospital VF. Upon admission, he had a serum potassium of 2.3mEq/L and required 1,050 mEq of potassium over 96 hours to achieve a serum potassium concentration of 4.3 mEq/L. This degree of potassium depletion was thought to be attributed to diuretic therapy without potassium supplementation. We believe that the hypokalemia contributed to the patient's refractory ventricular ectopy and that total body potassium repletion required the very large amount of potassium administration.

Case Reort

A 65 year old 90kg, white male suffered a witnessed cardiac arrest. Bystander CPR was performed until arrival of the advanced cardiac life support team. The patient was found to be in VF and required three DC countershocks for conversion to normal sinus rhythm. The resuscitative effort lasted 13 minutes; the patient received a 100 mEq IV bolus of sodium bicarbonate and a 100mg lidocaine IV bolus followed by a 2 mg/min infusion prior to transport to the emergency department. The initial twelve lead electrocardiogram showed normal sinus rhythm with a rate of 75 beats per minute, a P-R interval of 0.28 seconds, a QRS interval of 0.16 seconds, a QT interval of 0.44 seconds, marked left axis deviation, right

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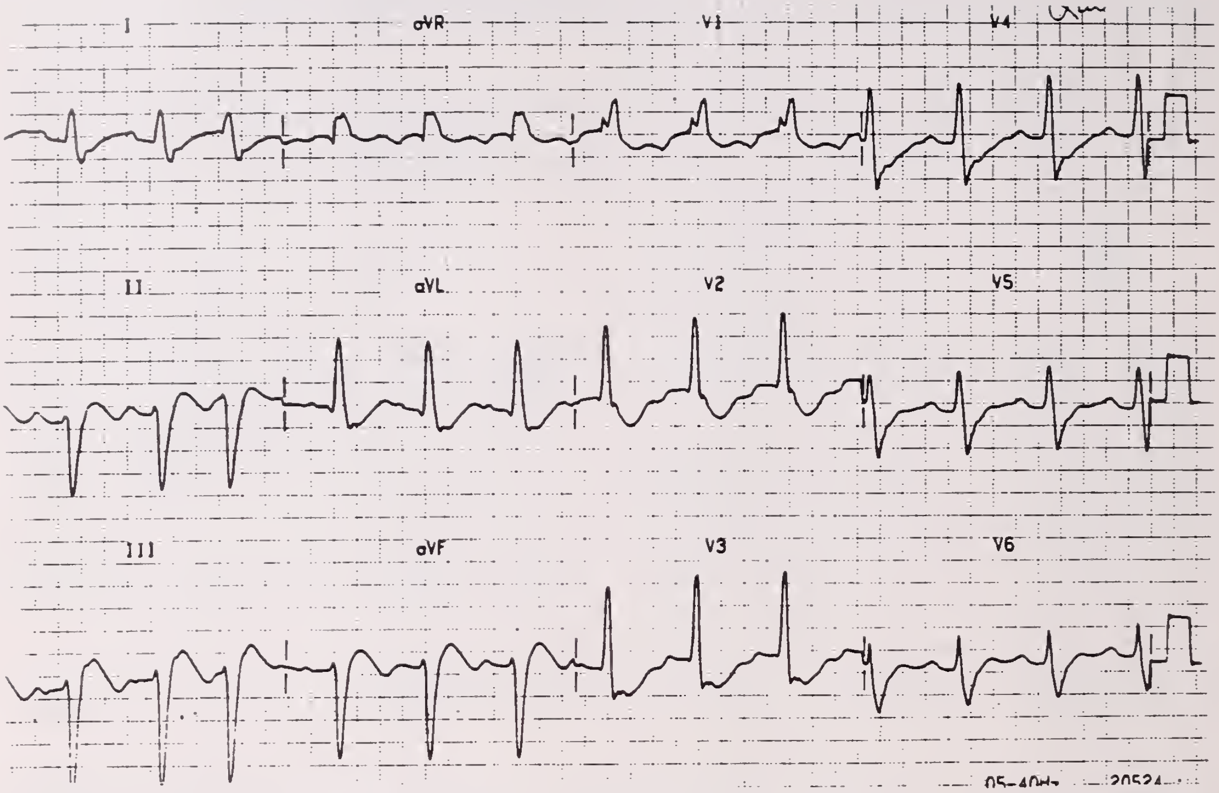

FIGURE 1: Initial twelve-lead electrocardiogram

bundle branch block and ST-T segment abnormalities, all which remained unchanged after correction of hypokalemia (Figure 1). The patient was hypokalemic (2.3 mEq/L) and hypoxemic (pO_2 55 torr, pH 7.38, pCO_2 44 torr, on room air). Other laboratory findings upon admission included: serum sodium 143 mEq/L, serum chloride 101 mEq/L, CO_2 content 27 mEq/L, blood glucose 259 mg/dl, blood urea nitrogen 17 mg/dl, serum creatinine 1.3 mg/dl, serum magnesium 2.6 mEq/L, serum quinidine 4.1 mcg/ml. Urinalysis revealed a specific gravity of 1.029, the urine sodium was 47 mEq/L, and the urine potassium was 100 mEq/L. The chest x-ray showed cardiomegaly with a widened mediastinum. Serial creatinine phosphokinase determinations were elevated, but all the MB fractions were within normal limits. Serial lactic acid dehydrogenase isoenzymes showed no evidence of myocardial infarction. Past medical history revealed an episode of viral myocarditis in 1972 and two previous myocardial infarctions (1969 and 1980) complicated by ventricular dysrhythmias and congestive heart failure. Cardiac catheterization performed in 1980 revealed triple vessel coronary artery disease with an ejection fraction of 30%. Medications upon admission included: quanabenz 4mg BID, digoxin 0.125 mg daily, quinidine gluconate 324mg QID, hydralazine 25 mg QID and furosemide 40 mg Q AM and 20 mg PM without potassium supplementation.

The treatment plan was to correct the hypokalemia and attain antidysrhythmic control. The patient received intravenous potassium chloride as needed to achieve a serum potassium concentration above 4.0 mEq/L (Figure 2). The patient was maintained on an intravenous lidocaine infusion at 2 mg/min which produced a serum lidocaine concentration of 2.0 mg/L (normal range 1.2 - 5.0 mg/L). Furosemide 20mg PO BID was begun on day two, and then decreased to 20mg PO daily on the fourth day. Quinidine gluconate 324 mg po every 8 hours was continued. Peak and trough serum quinidine concentrations after the fifth hospital dose were 2.4 mg/L and 1.7 mg/L, respectively (normal range 2.0 - 4.0 mg/L). On day three, a burst of sustained ventricular tachycardia necessitated a 100 mg bolus of lidocaine and the lidocaine infusion was increased to 4 mg/min; oral quinidine glu-

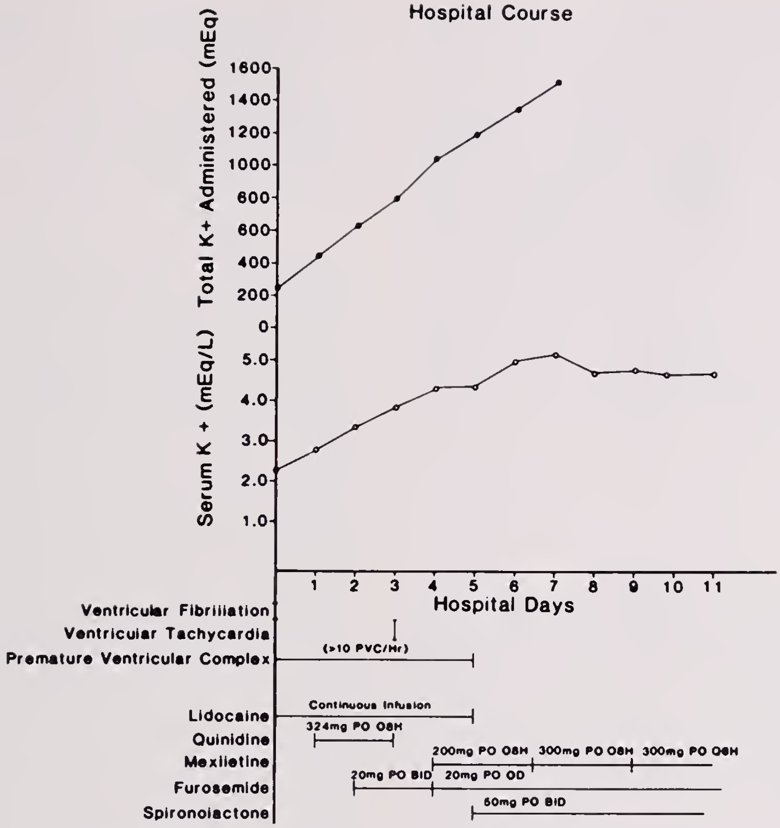

FIGURE 2: Patient's hospital course shows the serum potassium (K+) concentration, the amount of potassium administered, the patient's ventricular ectopy and anti-arrhythmic therapy.

conate was discontinued. Because the patient had previously failed to obtain good anti-dysrhythmic control on procainamide despite adequate serum concentrations and was not a suitable candidate for disopyramide, mexilitene 200mg PO Q 8 H was begun on day four. The dose was increased to 300 mg q 6 H for successful antidysrhythmic control. The patient was discharged on day eleven with a serum potassium concentration stabilized at 4.6 mEq/L and only the occurrence of rare premature ventricular complexes on mexilitene 300 mg PO Q 6 H.

Discussion

The serum potassium concentration does not accurately reflect the total body stores of potassium; however, the serum potassium concentration accounts for most of the clinically important effects of this electrolyte.[11,12] The transmembrane action potential of cardiac pacemaker cells is influenced by the serum potassium concentration.[12] Hypokalemia may affect the excitability and metabolic function of cardiac and skeletal muscle cells.[11,13] Potassium depletion can trigger a wide spectrum of atrial, junctional, and ventricular dysrhythmias by enhancing automaticity and altering conduction velocity in the myocardium.[11,12] The literature supports the belief that increased ventricular ectopy can result from diuretic-induced hypokalemia.[2,14] An increased susceptibility to digitalis-induced arrhythmias is well documented and widely accepted.[15] Patients with ischemic, hypertrophied, or a dilated heart are very vulnerable to hypokalemic-invoked ventricular dysrhythmias.[16,17]

A recent study by Hollifield and Slaton[18] found that thiazide diuretics cause hypokalemia and depletion of potassium stores. Hydrochlorthiazide therapy of 50, 100, 150 and 200 mg daily corresponded to serum potassium concentrations of 3.9±0.3, 3.4±0.2, 2.9±0.2, and 2.4±0.3 mEq/L, respectively, in patients without pre-existing evidence of heart disease. The more profound the hypokalemia, the greater the likelihood of PVC's. The occurrence of PVC's in these otherwise normal hypertensive patients with diuretic induced hypokalemia raises new concerns. Although hypokalemia may increase ventricular activity under ordinary circumstances, the hazard is more serious during times of stress, particularly if the stress involves myocardial ischemia.[5] This may explain the increase in sudden death noted in clinical trials in which diuretics, often in high doses, were the first and sometimes only anti-hypertensive drug used.[19,20]

Most researchers have felt that hypokalemia is asymptomatic unless it falls below 3.5 mEq/L, and that it is not considered severe unless it falls below 3.0 mEq/L.[21,22] However, recent literature has raised concern that serious arrhythmias may occur with serum potassium levels at or below 3.5 mEq/L and there is a definite link between diuretic-induced hypokalemia and an increase in cardiac arrhythmias observed in patients on diuretic therapy.[8,14,23] A retrospective survey of 414 patients admitted to a coronary care unit with acute myocardial infarction by Dyckner et al[24] showed a serum potassium concentration of less than 3.6 mEq/L was associated with a significantly increased frequency of supraventricular bradycardia, atrial flutter and atrial fibrillation. Ventricular ectopic beats and ventricular tachycardia were also more common in the hypokalemic patients. Beck & Hochrein[25] reviewed 565 cases of acute myocardial infarction and prospectively observed their serum potassium concentrations. Ventricular ectopic beats and tachyarrhythmias occurred with a significantly greater frequency in patients with a serum potassium concentration below or equal to 3.5 mEq/L. Serious arrhythmias such as ventricular flutter and fibrillation were more common in the hypokalemic patients. Cole et al[26] reported that in a coronary care unit, 48% of the hypokalemic patients, compared with 21% of those who were normokalemic, developed ventircular tachycardia or fibrillation. In a report of 1315 patients by Hulting,[27] the incidence of ventricular fibrillation within the first twelve hours of admittance to a coronary care unit was five times greater in patients with an initial serum potassium concentration below 3.5 mEq/L. These consistent findings of a demonstrated association between a lowered potassium concentration and ventricular arrhythmias should lead to the re-examination of the hypothesis that hypokalemia is harmless, an insignificant concern, and does not warrant prevention or correction.

Approximately 98% of the total body store of potassium is intracellular.[13] The serum potassium concentration is a function of two variables: 1) total body potassium content, and 2) the relative distribution of potassium between the extracellular and intracellular compartments.[28] Reductions in total body stores of potassium can result from loss of body mass and/or decreased intracellular potassium content. Chronic therapy with loop and/or thiazide diuretics has been shown on an average to reduce the serum potassium concentration by approximately 0.45 mEq/L and the total body potassium stores by approximately 10 to 15%.[4,12,13] Acid base changes,[10] insulin,[27] and exogenous catecholamines[29] have been shown to produce intracellular potassium shifts. However, none of these played a significant role in our patient's hypokalemia. Duke[2] also found that post-arrest hypokalemia was not explained by acid base changes, insulin, or exogenous catecholamine administration.

The unreliability of the serum potassium concentration to represent total body stores is a problem currently facing the clinician.[30] Accepted standards for potassium replacement are based upon the assumption that 100-200 mEq of potassium are required to produce a 1.0 mEq/L change in the serum concentration. If the serum concentration falls below 3.0 mEq, it is considered that a 1 mEq/L change represents a 200-400 mEq alteration in total body potassium content.[31] Based upon these guidelines, 500 mEq of potassium should have been sufficient to replenish the patient's total body potassium stores. In our patient, approximately 800 mEq of potassium were needed to achieve a serum potassium concentration of approximately 4 mEq/L. This is consistent with the belief that when potassium loss occurs gradually over an extended period of time, intracellular stores become so depleted that accepted standards for potassium replacement may be inadequate.[27] Concurrent potassium administration and diuretic therapy have been shown to increase renal potassium excretion.[32]

This could explain the large amount of potassium required by our patient.

In the absence of historical or clinical evidence for skin or gastrointestinal potassium losses, we believe the potassium depletion in our patient resulted from diuretic therapy without potassium supplementation.

It has been estimated that 1-8% of patients receiving quinidine experience syncope.[33,34,35] Syncope due to quinidine usually reflects the occurrence of a variety of polymorphic ventricular tachycardias known as Torsade De Pointes.[36,37,38,39] Torsade De Pointes (TdP) is a marked and uneven delay in myocardial repolarization, induced namely by bradycardia, QT prolonging agents such as the Type 1a antiarrhythmics,[40] amiodarone,[41] and phenothiazines.[42] However, it may also occur with hypokalemia[43] or hypomagnesemia.[44] The two most common causes of TdP are hypokalemia and quinidine therapy.[45] This is an important consideration in our patient since the combination of quinidine and hypokalemia present an additive potential for prolongation of the Q-T interval predisposing to episodes of TdP. Although quinidine induced ventricular arrhythmias tend to become more frequent as serum quinidine levels increase,[46] it is worthwhile to note that quinidine may cause episodes of TdP at serum levels that are well below those normally associated with toxicity.[47] We did not observe any episodes of Torsade De Pointes in this patient. His Q-T interval was not prolonged and serum magnesium level was within normal limits. However, we cannot exclude the synergistic arrhythmogenic actions of quinidine and hypokalemia.

Summary:

Ventricular ectopy is increased in patients taking diuretics, as documented by continuous Holter monitoring.[14] Diuretic-induced hypokalemia has been incriminated as an initiator of VF and sudden death in otherwise normal hypertensive patients and in patients with ischemic, hypertrophied or dilated myocardium.[2,19,20,48] Thompson and Cobb[10] reported a 49% incidence of hypokalemia among survivors of out-of-hospital VF. Unfortunately, the consequences of hypokalemia may not be an obvious and dramatic side effect, and often will go clinically undetected. The consequences are more subtle, but by slowly increasing the over-all risk for cardiovascular complications, are more deleterious. Considering the frequency of diuretic-induced hypokalemia, the potential and observed problems associated with such hypokalemia, and the relative ease of its correction, there should be a universal concern about hypokalemia and a wider adoption of measures to prevent its occurrence.[5] Our patient's hypokalemia was a major contributing factor in his dysrhythmias. In agreement with Kaplan,[5] we believe that patients' with chronically increased risk of VF, who receive long-term diuretic therapy, should also receive potassium supplementation with careful monitoring of their serum potassium concentration.

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The Influence of Lactation Consultant Contact on Breastfeeding Duration in a Low-income Population

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INCREASING concern has been raised regarding how to improve the likelihood of breastfeeding initiation and its subsequent duration among low income clients, who, as a group, are less likely to follow the well-documented national trend. Martinez has noted that the least rapid percentage increase in breastfeeding initiation occurred in mothers under 20 years of age, the unemployed, and those with lower incomes.[1] Race also is a strong predictor of likelihood of breastfeeding, with white mothers (61%) nearly twice as likely as black mothers (32%) to breastfeed.

The timing of the infant-feeding decision often is made prenatally[2] or earlier, thus suggesting that education designed to influence women to consider breastfeeding needs to be provided prior to, or at least during, pregnancy. Mansbach, etal,[3] however, found that less than 3% of the 276 pregnant women they followed were advised by the physician to consider breastfeeding. Among those who were breastfeeding at the time of their six week postpartum visit, 37% received **no** advice from the doctor. By 4½ months postpartum, only 13% of those who had weaned their babies (compared with 66% of those still breastfeeding) had received breastfeeding advice from their physician.

Lawrence[4] has noted that pediatricians, obstetricians, family practitioners, and registered nurses persist in assuming that the recent increase in breastfeeding is indicative of a passing fad rather than a continuing trend. While most report that they encourage breastfeeding, one-third of the physicians regardless of specialty reported that they did not initiate discussions about infant-feeding with their patients.

Among pregnant women on WIC, Collins, etal[5] found that 11% were discouraged by one or more persons from nursing. Of those who chose to bottlefeed, the majority stated that the bottle was "more convenient" and that formula was "just as good as breastfeeding." For women under 20 years of age, the most frequent reason for not planning to nurse was their need for gainful employment. These findings suggest that mothers need information about the advantages of breastfeeding, how to combine breastfeeding with paid work or other activities, and an awareness that other women in similar circumstances have chosen to breastfeed.[6]

Work by Bevan, etal[7] in New York City suggests that initiation of breastfeeding may mirror national trends, but that duration of breastfeeding may be short-lived. Among their WIC clients, early introduction of human milk substitutes was associated with shorter breastfeeding duration, suggesting a need for improved education relating to breastfeeding technique.

Among Nebraska families, Brogan and Fox[8] found breastfeeding initiation to be similar among low- and middle-income groups, although weaning earlier than one month was three times as likely among low as among middle-income families. Maternal education level and income influenced the timing of non-milk foods; breastfed infants were introduced to solids later than bottle-fed infants.

Johnson, Garza and Nichols[9] found that beside teaching in the immediate hospitalized postpartum period significantly improved breastfeeding success in an inner-city poverty

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Table 1

DEMOGRAPHIC CHARACTERISTICS OF SAMPLE POPULATIONS

		1983	1984	1983-84 comparisons
GENDER OF INFANTS	Male	56%	64%	n.s.
	Female	44%	36%	
MATERNAL AGE	Range	18-41	18-44	n.s.
	Mode	25	20,21,24	
	Median	24	24	
	Mean	24.72	24.78	
MATERNAL RACE	White	64%	76%	n.s.
	Black	22%	14%	
	Other Non-White	14%	10%	
MARITAL STATUS	Married	30%	62%	<.01
	Single	70%	38%	
PARITY	Range	1-4	1-5	<.05
	Mode	1	1	
	Median	1	2	
	Mean	1.44	1.78	
PREVIOUS BREAST-FEEDING EXPERIENCE	None	96%	86%	n.s.
	One or More Infants	4%	14%	

population in Texas. Gulich[10] notes that what the new mother knows can influence her degree of breastfeeding success. Specifically, the maternal benefits of breastfeeding, nipple care during pregnancy, the need to wake a sleepy baby for feeding, and infant stool characteristics were associated with successfully breastfeeding beyond one month.

This study was designed to determine whether contact with a lactation consultant trained to provide information about, and support for, breastfeeding prenatally and during the postpartum period might influence breastfeeding duration among a population of WIC clients.

The Special Supplemental Food Progam for Women, Infants and Children was authorized by a September 1972 amendment to the Child Nutrition Act of 1966. The general purpose of the Program, as specified by legislation and defined by USDA, is to make specific foods available to infants and children until their fifth birthday, and to pregnant and breastfeeding women who are determined to be at nutritional risk, and who meet income and residency guidelines. In addition to the provision of specific supplemental foods, a program of health and nutrition education is included. As a major goal, improving client understanding of the benefits of breastfeeding has been undertaken. Breastfeeding information and support is designated as a major goal of the national WIC program. In one Nebraska office, the services of a lactation consultant were offered for a six-month period to assist state and clinic staff in providing information to the clients regarding the techniques basic to improving duration of breastfeeding throughout the state. Additionally, clients were given an opportunity to see the lactation consultant during pregnancy and/or following the baby's birth.

Materials and Methods

For the index year, 1983, and for the comparison year, 1984, a nurse at a WIC clinic randomly identified 50 infants each year who were breastfeeding at the time of their registration.

Table 2

BREASTFEEDING DURATION IN THE
INDEX AND COMPARISON YEARS IN PERCENT

Breastfeeding Duration	1983	1984
<8 weeks	46	28
8-12 weeks	22	8
13-16 weeks	10	12
17+ weeks	22	52

$x^2 = 11.60$ df = 3 $p < .02$

Range	1-21+	1-21+
Mode	4	21+
Median	8	21+
Mean	9.40 weeks	14.56 weeks
Total weeks* breastfeeding (entire cohort)	470	728**

*Counting highest duration as 21 weeks, this figure underrepresents actual duration of those infants breastfeeding longer than 5 months.

**Statistically significant at <.05; a 35% increase in baby-weeks of breas

The charts of each mother and baby were reviewed, and the following information was recorded: mother's age at the time of the infant's birth, infant's gender, mother's marital status, race, parity, previous breastfeeding experience if any, place of the infant's birth, breastfeeding duration, and, if part of the 1984 sample, lactation consultant contact. Women in the index year (1983) and comparison year (1984) were remarkably similar (See Table 1). With the exception of marital status and parity, the groups were indistinguishable. Although slightly more women in 1984 had more than one child, previous breastfeeding experience was not significantly more likely for them than for the women in the 1983 sample.

Results

Breastfeeding duration in 1983 was markedly shorter than in 1984, as seen in Table 2, and Figure 1. One element influencing breastfeeding duration was contact with the lactation consultant (See Table 3, Figure 2). Half of the women who had no contact with the lactation consultant weaned their breastfeeding babies

Figure 1

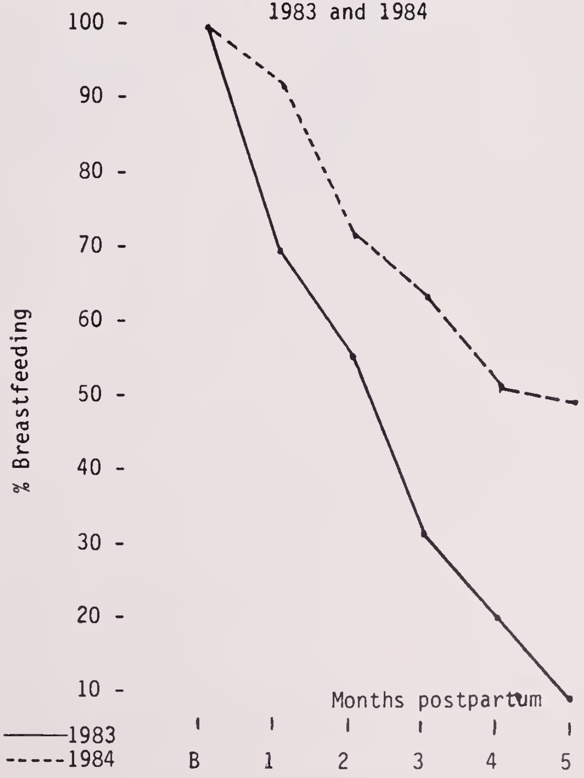

Breastfeeding Loss Rates Over Time
1983 and 1984

Table 3

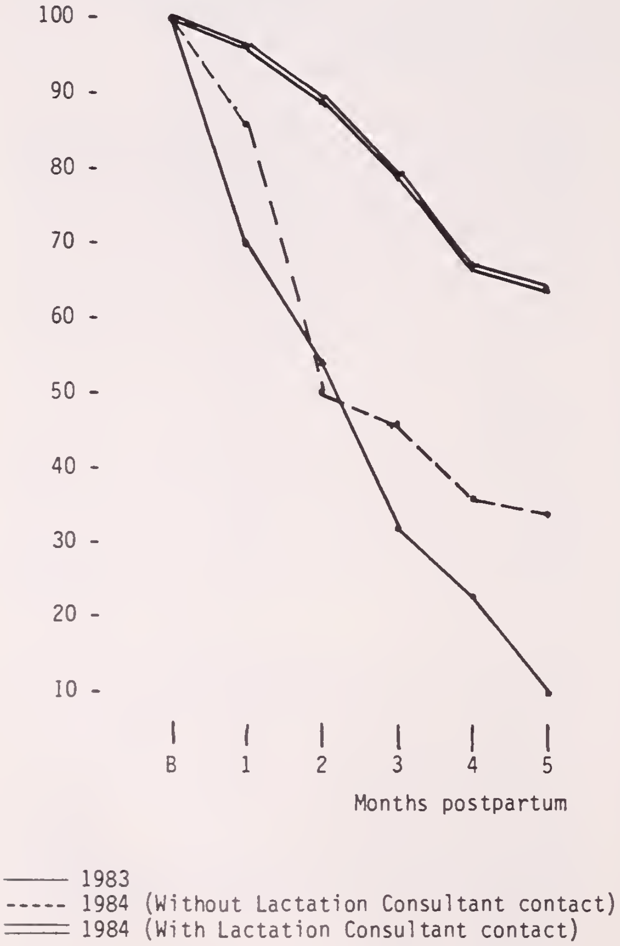
LACTATION CONSULTANT CONTACT IN 1984
AND BREASTFEEDING DURATION IN PERCENT

Breastfeeding Duration	Lactation Consultant Contact None	Lactation Consultant Contact One or More	Total
<8	50	11	28
8-12	4	11	8
13-16	14	11	12
17+	32	68	52
TOTAL	44	56	100

$x^2 = 11.96$ df = 3 $p < .01$

Figure 2

Breastfeeding Loss Rates Over Time, 1983, 1984
(With and Without Lactation Consultant Contact)



before eight weeks. Of those women who had one or more contacts with the lactation consultant, 68% nursed their infants longer than four months.

Because three sociodemographic variables may have contributed to breastfeeding duration, maternal age, race and marital status also were examined (See Table 4). In general, percent of early weaning decreases, and percent of longer breastfeeding duration increases, from 1983 to 1984, and from no to one or more contacts with the lactation consultant. Also important is the degree to which contact with the lactation consultant appears to nullify the impact of maternal age, race, and marital status on breastfeeding duration. This finding suggests that lactation consultant contact is a powerful intervening variable when applied to a population where some women are young, and/or non-white, and/or single.

Discussion

Health care professionals concerned about increasing breastfeeding duration in Nebraska may wish to provide pregnant and postpartum patients with the services of a lactation consultant. Such contact prenatally may serve to highlight the significant health benefits of breastfeeding to the infant which persist across income categories and which have been found to strengthen as income decreases.[11] Benefits to the mother, particularly those continuing

Table 4

SOCIODEMOGRAPHIC CHARACTERISTICS AND LACTATION CONSULTANT
CONTACT BY YEARS AND BREASTFEEDING DURATION IN PERCENT

Mother's Age

	1983		1984a (No Lactation Consultant)		1984b (Lactation Consultant)	
	<25	25+	<25	25+	<25	25+
<8 weeks	50	42	57	33	8	13
8-12 weeks	23	21	0	11	17	13
13-16 weeks	8	13	0	33	8	7
17+ weeks	19	25	43	22	67	67
TOTAL	52	48	63	37	44	56

Mother's Race

	1983		1984 (No Lactation Consultant)		1984 (Lactation Consultant)	
	Non-White	White	Non-White	White	Non-White	White
<8 weeks	33	53	80	39	0	16
8-12 weeks	22	22	0	6	13	11
13-16 weeks	22	3	0	17	13	11
17+ weeks	22	22	20	39	75	63
TOTAL	36	64	22	78	30	70

Marital Status

	1983		1984 (No Lactation Consultant)		1984 (Lactation Consultant)	
	Single	Married	Single	Married	Single	Married
<8 weeks	57	20	54	40	17	10
8-12 weeks	23	20	8	0	0	14
13-16 weeks	11	7	8	20	17	10
17+ weeks	9	53	31	40	67	67
TOTAL	70	30	57	43	22	78

Category	Comparisons	Significance
1983	Marital Status	<.01
Single women	1983-1984	<.05
< 25	1984a-1984b*	<.05
Non-White	1984a-1984b	<.02

*1984a refers to women who had no Lactation Consultant contact.
1984b refers to women who had Lactation Consultant contact.

and/or increasing in importance if the mother is gainfully employed outside the home (or going to school), also can be discussed with the pregnant woman during the period when she is susceptible to suggestions relating to infant feeding.

In the early postpartum period, contact with the lactation consultant can assist the mother in the critical first month of her breastfeeding experience when minor difficulties are most likely to arise and are most amenable to solutions.

In the later postpartum period, the lactation consultant can assist mothers in maintaining the breastfeeding relationship as they gradually, and in an appropriate and timely fashion, add solid foods to the infant's diet.[12] By serving as a consistent, easily-identifiable resource for patients and professionals, the lactation consultant assures that breastfeeding information and support is provided to augment the information and support already offered by other health professionals.

Summary

The presence of a lactation consultant added to the information and support for breastfeeding mothers already offered by other health professionals in a WIC office in Nebraska. Client contact with the lactation consultant resulted in a statistically significant decrease in early weaning, and an increase in the percentage of mothers who continued to breastfeed through the fourth month of the baby's life. These findings suggest that lactation consultant services may be especially helpful when such sociodemographic variables as age, marital status, and race may negatively influence the breastfeeding experience.

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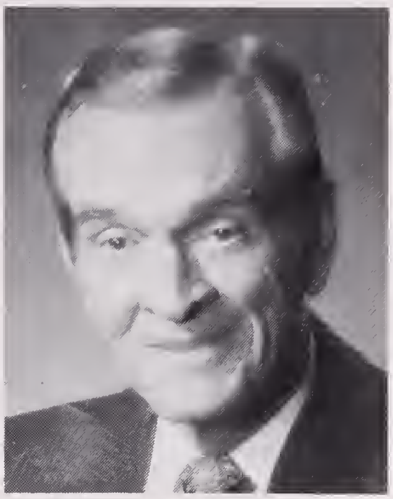
President's Page

THOUGHTS ON ETHICS OF RATIONING

PART II



Francis D. Donahue, M.D.

It is not clear at this time where all the changes will take us but evidence is accumulating which strongly suggest some segments of the population are feeling the effect of rationing. This can only increase with each passing year. The poor, elderly, those with inadequate or no insurance are not only increasing in number but many have greater need for health care. It is not only a socioeconomic problem but an ethical one as well.

We owe society a style of medical practice in which diagnostic and therapeutic procedures will be medically proper and performed as economically as possible. We owe our individual patients the medical care we feel is best for them, the quality of which will never be compromised by cost considerations. We should not ignore the cost aspect but quality is our goal. It is better for a patient to have a doctor who in quest of excellence may do too much than have one whose approach is limited by regulatory and economic constraints. For hundreds of years the first rule of medicine has been Primum non nocere (first do no harm). It should not become Caveat emptor (let the buyer beware). The problems of solving complex and difficult problems such as when to discontinue life support or how much care for the hopelessly ill will not find unanimous agreement among caring physicians but each one of us must make the decision on individual patients for medical reasons not economical. Many believe the influence and voice of the physician will wane as the industry grows horizontally and vertically but this chance will lessen if the patients know fully well who their advocates are. By the same token we will be soundly criticized for not giving economics the top priority but informed patients and their families will not be among them.

Dr. Avorn very well described this dilemma using the "life boat mentality". This metaphor likened society facing tough decisions on resource allocation to an overcrowded and leaky life boat in which the passengers must choose who will be thrown overboard in order for the rest to survive. While the planners are philosophizing on the question who will be tossed overboard the physicians should make it clear their goal is to rescue them at any cost.

Obviously there will be times when our capabilities will not permit supplying the care one needs due to restraints and constraints. Patients or their surrogates must be made aware of this and the reasons fully explained. Organized medicine could assist its members if documented evidence is made available to it.

Francis D. Donahue, M.D.

The Auxiliary

AMA AUXILIARY NATIONAL CONVENTION 1985

The sixty-second annual American Medical Association Auxiliary Convention was held June 16-19 at the Drake Hotel, Chicago, Illinois.

The convention opened on Sunday, June 16, with National Program Previews. Mini-briefing sessions on AMA-ERF, Health Projects, Legislation and Membership provided valuable information to be used in the 1985-86 year.

Billie Brady attended the opening of the AMA House of Delegates and presented the Auxiliary contribution of $1,388,713.84 for AMA-ERF. This represents an increase of $38,271.75 over last year. Helen Krause walked in the Fun-Run for AMA-ERF on Saturday and earned a finish ribbon.

All of the State Presidents were presented at the 5 o'clock opening of the Auxiliary House of Delegates, with Ardis Grace representing Nebraska. It was a most impressive ceremony. After state roll call of delegates, Betty Drew introduced the resolutions, which included Nebraska Resolution #3 on Education on Early Detection of Colorectal Cancer.

Senator David Durenberger, R-Minnesota, was the keynote speaker, talking about "Health Care in America". A reception honoring Billie Brady and Mary Kay McPhee followed.

Reference Committee hearings were held following the AMPAC breakfast on Monday morning. Ardis Grace was given a chance to introduce and explain the Nebraska Resolution on Colorectal Cancer.

Mark Russell was speaker at a noon luncheon honoring National Auxiliary Past Presidents and Honorary Members.

A total of 339 delegates were counted at the 2 o'clock session of the House of Delegates. Officers elected were: President, Mary Kay McPhee; President-Elect, Pat Durham, Texas; Eastern Regional V.P., Mary Strauss, Maryland; North Central Regional V.P., Jean Cavanaugh, Kansas; Southern Regional V.P., Jean Hill, Mississippi; Western Regional V.P., Doreen Evert, California; Recording Secretary, Barbara Quickstad, Idaho; Treasurer, Betty Szewczyk, Illinois. Directors elected were: East, Lauretta Jordan, Pennsylvania and Belle Tanenhaus, New York; North Central, Ila Lushbough, South Dakota and Diane Hinderliter, Illinois; South, Anne Pitchford, Texas and Sherry Strebel of Oklahoma; West, Marian Monnahan,Utah and Mary Randolph, Washington.

Delegates attended a reception for Pat Durham that evening.

Nebraska delegates met before 7 a.m. on Tuesday morning to caucus. Dorothy Olson met with us to discuss candidates and resolutions. Reference Committee reports were given at the general meeting, with Reference Committee B speaking in favor of the Nebraska Resolution. Voting followed, and the following resolutions were adopted: 1. Change of 4 to 3 members of Board of Directors to be on nominating committee; 2. Unified membership study; 3. Education on Early Detection of Colorectal Cancer; 4. Programs for Spouses of Impaired Physicians; 5. Eating Disorders — Anorexia Nervosa and Bulimia.

The Nebraska Delegation was proud to have Dorothy Olson, Chairman of ByLaws, give her report.

Helen Krause wore her "Big Red" hat when she gave her two minute report of her year as President of the Nebraska Auxiliary, centering it around the smallest auxiliary, Burt-Washington with 8 members, and the Fitness Trail they recently completed and dedicated.

Luncheon speaker on Tuesday was Uwe E. Reinhardt, Ph.D. with "The Health Care Brawl" as his topic. Afternoon voting for Nominating Committee resulted in the following being elected: Billie Brady, Donna Fields from Board of Directors; Kay Reardon and Cecile Keshishian, East; Rosemary Hill and

Ann Rempel, North Central; Barbara Blanton, Southern; and Diana Lee from Western.

Tuesday afternoon symposium featured noted author and lecturer Florence Littauer. Her topic was "How to Understand Others by Understanding Yourself". Tickets were available to see "Cats" in the evening.

Dr. Joseph F. Boyle was a speaker at the Wednesday morning session. He applauded the auxiliary for their work and support and reminded us of the need for a close relationship between the Medical Association and the Auxiliary, and that always THE PATIENT COMES FIRST.

We lost our membership challenge made by Iowa and had to present them with 25 pounds of steaks when Patricia Minchin from Iowa asked "Where's the beef?"

Seeing Mary Kay McPhee sworn in as President was especially moving to us as we here in North Central have gotten to know her well. In her inaugural address she stressed the importance of COMMITMENT, CONCERN and COOPERATION.

We are grateful for the opportunity to have been delegates and are proud to belong to a very special organization, the NMAA.

Helen Krause Colleen Adam
Ardis Grace Desta Osborne

"NEBRASKA IS PROUD TO HAVE INTRODUCED THE RESOLUTION CONCERNING THE EDUCATION ON EARLY DETECTION OF COLORECTAL CANCER, SPEARHEADED BY MRS. LESLIE GRACE, PRESIDENT, NMAA."

Welcome New Members

Nancy Tilson-Mallett, M.D.
204 N. Randolph
Weeping Water, NE 68413

Jergen L. Barber, M.D.
117 No. 18th
Norfolk, NE 68701

Timothy R. Lieske, M.D.
2221 South 17th St.
Lincoln, NE 68502

Jeffrey S. Knerl, M.D.
Ponca, NE 68770

Roy W. Holeyfield, M.D.
404 W. Mission Ave.
Bellevue, NE 68005

Coming Meetings

1985 FALL SESSION — Sept. 19-21 — Lincoln Cornhusker.

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

EMERGENCY MEDICINE REVIEW — September 23-28, 1985 and will be repeated on October 1-12, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. Credit: 45 hours AMA Category I, AAFP Prescribed & ACEP Category I. Fee: $425 physicians, $325 residents in training. Content: This course will provide physicians engaged in the evaluation and treatment of urgent and life threatening conditions with an in-depth review of emergency medicine. Special attention will be given to the recognition of conditions that must be identified immediately, and evaluation of nonemergency conditions. Daily national board type exams will be given. Contact: Marge Adey, Coordinator, Center for Continuing Education, University of Nebraska Medical Center, 42nd and Dewey, Omaha, Nebraska 68105. (402) 559-4152.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Cocktail Reception — Friday, October 11, 1985, 5:30-7:00 p.m., in conjunction with the American Academy of Family Physicians Meeting, Marriott Hotel, Anaheim, California. All alumni, spouses and friends are invited. Cash bar.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Roundup and Reception in Omaha, Monday, October 28, 1985, 6:00-7:30 p.m., Red Lion Inn Ballroom; in conjunction with the Omaha Mid-West Clinical Society Postgraduate Assembly. Cash bar. All alumni, spouses, faculty and friends are cordially invited. Followed at 7:45 p.m. with 50-year dinner in Nebraska Room, Red Lion Inn. Class reunions will be held in Omaha at the end of October for classes ending in "5" and "0".

CREIGHTON UNIVERSITY

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

GYNECOLOGIC MALIGNANCIES — Sept. 27, 1985, Boystown National Institute Auditorium, Omaha, Nebraska. Co-sponsored by the departments of medicine, surgery, obstetrics and gynecology and Saint Joseph Hospital for primary care physicians, general surgeons, gynecologists, and nursing personnel. Program Director: James A. Mailliard, M.D., Division of Oncology, Creighton University. For information: Division of CME, Creighton University.

HEART AND MIND — Oct. 10-12, 1985, Marriott's Tan-Tar-A Resort, Lake of the Ozarks, Osage Beach, Missouri. Program Directors: Emmet M. Kenney, M.D. and Syed M. Mohiuddin, M.D. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

HEART AND MIND: NEUROCARDIOLOGY UPDATE — September 7, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

ANNUAL SURGERY SYMPOSIUM — September 12-13, 1985. Sponsor: University of Kansas Medical Center. Location: Hyatt Regency Hotel, 2345 McGee, Kansas City, Missouri.

KANSAS CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS MEETING — September 14-15, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

A SPECIAL WORKSHOP ON THE USE OF THE CO_2 LASER IN ENT SURGERY — September 19-20, 1985, November 14-15, 1985. Sponsor: University of Kansas Medical Center, Department of Otorhinolaryngology. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 14 hrs. AMA Category I. Fees: $625. Maximum Enrollment: 9 persons per session.

MEDICINE AND RELIGION: The Supreme Being, the Supreme Court, and the Almighty Dollar — October 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Target Audience: Physicians, Nurses, Clergy, Social Workers, Nursing Home Administrators. Contact: Promotion Coordinator, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4488.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

2ND MIDWEST REGIONAL CONFERENCE ON WOMEN IN MEDICINE — September 27, 28, and 29, 1985. Sponsor: University of Kansas Medical Center. Location: Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri. Credit: 8 hrs. AMA Category I, 8 hrs. AAFP. Fees: $130 Physicians, $60 Other Health Professionals, $20 Students. Guest Speaker: Ellen L. Shulman, M.D., NASA, Lyndon B. Johnson Space Center, Houston, Texas.

ANNUAL INTERNAL MEDICINE SYMPOSIUM — October 9, 10, 11, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

53RD ANNUAL POSTGRADUATE ASSEMBLY — Omaha Mid-West Clinical Society, October 28, 29, 30, 1985, The Red Lion Inn, Omaha. For information contact Miss Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 7363 Pacific Street, #205-B, Omaha, Nebraska 68114.

3RD ANNUAL CHRONICALLY ILL AND AGING CONFERENCE — November 21-23, 1985, Oklahoma City, Oklahoma. CME Credits given. For information contact: Dr. John A. Mohr (III), VAMC, 921 NE 13th, Oklahoma City, OK 73104 or call 405-270-5149). (PLEASE NOTE THIS IS THE WEEKEND OF THE OKLAHOMA UNIVERSITY - NEBRASKA GAME AT OKLAHOMA CITY, OKLAHOMA!)

SCHEDULED CONFERENCE

A national conference on "Ethics on the Front Lines of Medical Care: **Bioethical Dilemmas at the Beginning and the End of Life**" will be held at the Marriott City Center Hotel, Denver, Sept. 4 through 6, 1985.

The conference will bring together the practical and philosophical issues of biomedical ethics through joint sponsorship of the meeting by the Center for Applied Biomedical Ethics at Rose Medical Center, Denver; Presbyterian/St. Luke's Medical Center, Denver; and the Hastings Center, Hastings-on-Hudson, N.Y.

The final session of the meeting at 2 p.m. on Sept. 6 will be open to the general public and feature a presentation on "What is a Profession and What is the Medical Ethic?" by Leon R. Kass, M.D., Ph.D., Professor of the Liberal Arts of Human Biology, University of Chicago, Chicago.

Following Dr. Kass' speech, there will be a discussion of the subject by Colorado Governor Richard D. Lamm; Frederick R. Abrams, M.D., Director of the Center at Rose; and Glen Webster, Ph.D., Professor of Philosophy, University of Colorado, Denver.

Audience questions will be taken from the floor.

In discussing the background for the conference, Dr. Abrams said, "Decisions about medical care are no longer the private terrain of health professionals. A sophisticated public is calling for its rightful voice in making such choices.

"The public does not make choices in a vacuum. It is the role of philosophers first to reflect on, and then enunciate the human values questions that the public must eventually answer. The role of health care practitioners in this process is to translate publicly confirmed philosophical decisions into practical action," he added.

"The conference on Sept. 4 through 6 offers participation by all three groups: philosophers, practitioners and the lay public — the theoretical and the practical. The resulting dialog promises to prove valuable for anyone interested in the impact of differing values on medical practice at the beginning and the end of life," he said.

The cooperative effort of two Denver health care institutions and a national center for the study of medical ethics brings to a common forum a faculty of formally trained ethicists and a contingent of health care practitioners and other professionals. They will explore many issues with conference participants, including whether all that medical practice knows how to do for patients should, indeed, be done.

The Center for Applied Biomedical Ethics at Rose Medical Center was founded in 1984 to serve as a "front line" ethical resource for medical professionals, clergy, patients and their families, and community members.

The Hastings Center was established in 1969 to address the ethical problems of rapid development in medicine, biology, the behavioral sciences and the professions. It carries out research in such areas as death and dying, genetic counseling and engineering, behavior control, health policy, and the foundations of ethics and professional ethics.

Registration: The Center for Applied Biomedical Ethics, Rose Medical Center, 4567 E. 9th Ave., Denver, CO 80220.

Doctor Jerald R. Schenken elected to the AMA Board of Trustees

Doctor Jerald R. Schenken expressing his appreciation to the House of Delegates following his election.

Doctor John D. Coe nominating Doctor Jerald R. Schenken for election to the Board of Trustees of the AMA.

(More photos on following 3 pages)

Photos of the campaign electing Doctor Jerald R. Schenken to the Board of Trustees of the American Medical Association at the June, 1985, meeting of the AMA House of Delegates.

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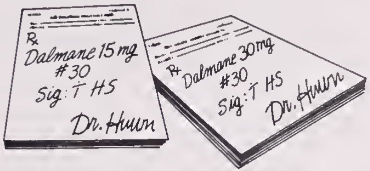

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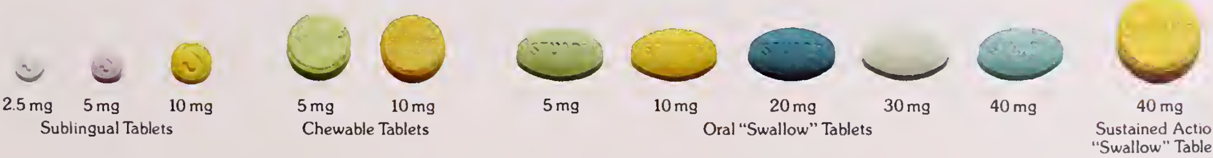

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Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin Moreover physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

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Before prescribing, see package circular for full product information. HYD-1085-13

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AMA News Notes

AMA's 'Malpractice' Bill is expected to be introduced in Congress by Sen. Orrin Hatch (R, Utah) after Congress reconvenes Sept. 4. Hatch, who is the chairman of Labor and Human Resources Committee and a member of the Judiciary Committee, announced in a soon-to-be-published interview with **American Medical News** that he intended to introduce the Association's draft professional liability bill, which, he said, reflects the proper approach to take in this area. He noted, however, that he may make some modifications in the draft legislation, including a reduction of the proposed federal funding. As written, the bill provides for federal incentive grants to states that enact specified tort reforms and risk control measures. According to the Office of the General Counsel, the AMA has commissioned actuarial studies to estimate the savings that would accrue to the federal government if Congress adopted the draft bill.

* * *

Medicare Participation Rate for non-federal patient care physicians was 37.2% during the first year of the participating physician program, according to the AMA Center for Health Policy Research. The program, which was created by the Deficit Reduction Act of 1984, offered incentives to physicians who agreed to accept assignment for all Medicare services. In a study of 476 MDs care physicians, excluding residents, the center found that physicians were 'extremely cautious' last year in making the decision about whether to participate. For the most part, they based their decision on their previous assignment history. Participation was more likely for physicians who had previously assigned a larger percentage of patients or whose usual fees were relatively close to the Medicare prevailing fee. Board-certified physicians were less likely to join the participating physician program last year. Physicians located in urban areas were more likely to participate, possibly because of a larger elderly population, more competition with other physicians, and more information in urban areas.

* * *

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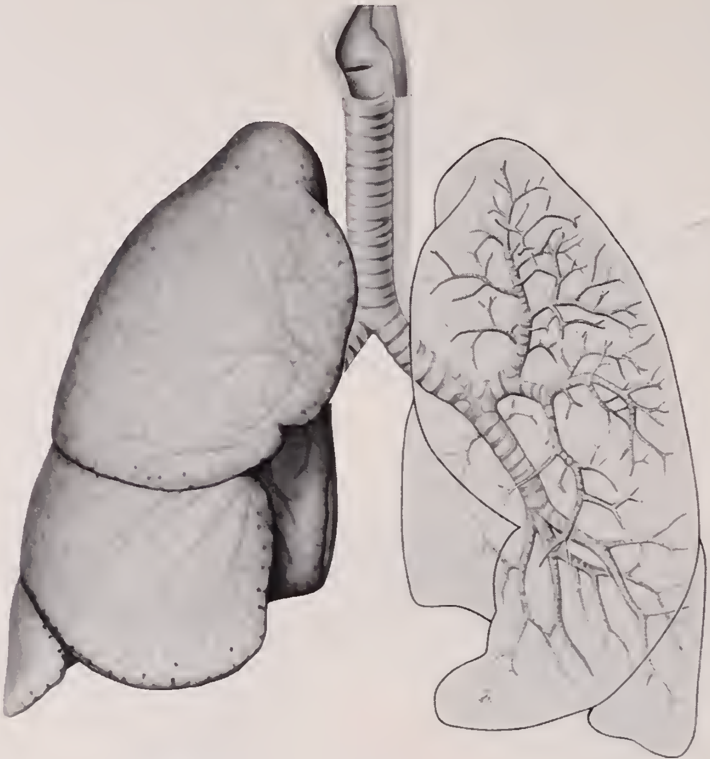

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H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
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Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae* and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics including Ceclor should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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THE NEBRASKA MEDICAL JOURNAL

Pre-Admission Certification

FRANCIS D. DONAHUE, M.D.
President, Nebraska Medical Association

RECENTLY Blue Cross and Blue Shield have agreed to accept the employees of the State of Nebraska under a policy with a proviso entitled Pre-Admission Certification.

This program is ushered in with the lofty motive of reducing costs. When examined carefully, it is nothing more than another method attempting to limit access to health care.

After the attending physician finishes his or her exam and decides hospitalization is indicated, he or she must submit findings to a nonphysician who will evaluate these findings and plan of action. This person will then decide if hospitalization is indeed needed and if so, state the length of stay permitted and issue other opinions. Taking the time to provide this information and awaiting an answer, particularly if appealed, serves as further impediment to both physicians and patients.

When insurance companies assume the management of a sick person's care, heralding this as great service to the public as costs might be reduced, the quality of care could well be destroyed and the patients made to suffer.

Patients should be thoroughly informed of the facts and the inherent dangers. Unqualified people cannot assume a role as the sick person's advocate.

While we are here addressing a specific program, the concept is much wider in scope and already with us and in time will expand through other mechanisms such as DRGs and other federal health care programs.

It is important that any action that tends to dilute the quality of care the public deserves be recorded and forwarded to the NMA office. This will serve as a repository of occurrences to help support our position.

ORIGINAL ARTICLES

Renovascular Hypertension in a Child: Percutaneous Transluminal Renal Artery Angioplasty

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HYPERTENSION (HTN) in the pediatric population is an uncommon but an important finding. Significant morbidity and mortality can occur in childhood just as in the adult population. In children under the age of 18 years secondary causes of HTN are more common than essential HTN. Mildly elevated pressures may be a common daily occurrence as pressures are known to be quite labile in children and adolescents. However, when diastolic pressures above the 95th percentile persist, a thorough search for underlying causes is warranted. A case of an 8 year old boy with hypertension is presented and a discussion and review of the literature follows.

The incidence of HTN in children is estimated to be 1-2%, in adolescents approximately 10%, while in black young adults it may reach 25%. Several screening studies of school age children have yielded prevalence rates of over 30% initially, but on follow up examination the rates have decreased to those noted above. This is presumably due to the relatively labile nature of blood pressure in children. The majority of adolescent HTN is secondary, but in some subgroups, especially blacks and white males, 80-100% may be essential in nature.[1] Recently, several studies[2-4] have challenged the previously held opinion that black children as a group tend to fall in the higher percentiles as compared to white children. The reference percentiles for children and adolescents were prepared after sampling large populations of white children. After comparing pressures to recently reported reference percentiles for blacks,[3] many black children previously considered hypertensive may be recategorized as normotensive.

Glomerular disease accounts for an estimated 80% of secondary HTN with renovascular lesions representing 9-26%.[5] Generally these vascular lesions are amenable to surgery and represent an important, potentially curable cause of HTN. Indeed, renovascular disease is second in frequency only to coarctation of the aorta as a surgically correctable cause of pediatric HTN.[6] Since Goldblatt's studies in 1934, renal occlusive disorders have been a well known cause of HTN.[7] A local overproduction of renin by an ischemic kidney or segment of renal parenchyma secondary to an ipsilateral stenotic or completely occluded renal artery has been demonstrated by a number of investigators.[8-11] Hyperreninemia leads to secretion of angiotensin II, a potent vasoconstrictor, and secondary hyperaldosteronism with an expansion of the extracellular volume.

Case Report

J.K., an 8 year old white male, was a healthy, athletic farmer's son. His blood pressure was found to be 164/110 mm Hg at rest and 180/120 mm Hg after brief exercise by his mother who is a nurse. There was no previous history of hypertension and he denied headaches, visual disturbances, or syncopal episodes. Sodium intake was not excessive but he recently began to feel overly thirsty. There was no history of renal disease and he was not currently taking any medications. He had an uncle who experienced a brief episode of transient hypertension at age 25. His past medical history and review of systems was noncontributory.

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His temperature was 98.9 F, the pulse was 84, and respirations were 20. The blood pressure in the left arm was 160/110 mm Hg, and in the right arm 165/110 mm Hg, with similar pressures in the lower extremities. The head and neck were normal without fundoscopic evidence of retinal hypertensive changes. The lungs were clear. The second heart sound was prominent and split, varying with respirations. The abdomen was normal without audible bruits.

His white blood cell count was 6300 with 53% segs, 0 bands, 35 lymphocytes, 4 monocytes, and 8 eosinophils. Hemoglobin was 13 gm% and hematocrit 36%. The prothrombin time was 12 seconds and partial prothrombin time was 29 seconds. A urinalysis was within normal limits. A 24 hour urine showed epinephrine levels of 12.2 mcg/24 hr (0.2-10.0 mcg/24 hr.), and normal levels of norepinephrine, dopamine, vanillylmandelic acid, and aldosterone. Creatinine clearance was 188 ml/min/1.73m.[2] Electrolytes and thyroid studies were within normal limits. Supine peripheral plasma renin was elevated at 4.3 ng/ml/hr (1.1-3.9 ng/ml/hr) but upright renin was within normal limits.

An echocardiogram and EKG suggested mild left ventricular hypertrophy. Ultrasound and an intravenous pyelogram revealed a significantly smaller left kidney, with a greater concentration of contrast on the left and a delay in its excretion. The calyces were not distorted. An abdominal aortogram was performed which showed a hypoplastic single left renal artery which was nearly occluded 15 mm distal to its origin (Figure 1). Renin activity was sampled from several sites during this procedure: aorta 9.2 ng/ml/hr, inferior vena cava 8.7 ng/ml/hr, right renal vein 8.6 ng/ml/hr, and left renal vein 35.5 ng/ml/hr.

Percutaneous transluminal dilation of the left renal artery was performed with good post dilation appearance. There was a pressure gradient across the stenosis of 60 mm Hg prior to angioplasty which measured 20 mm Hg after the procedure. The patient had an uneventful recovery and 8 weeks after the procedure, his blood pressure was 95/60 mm Hg.

Discussion

Although its population contained a greater percentage of adults than children, the Co-

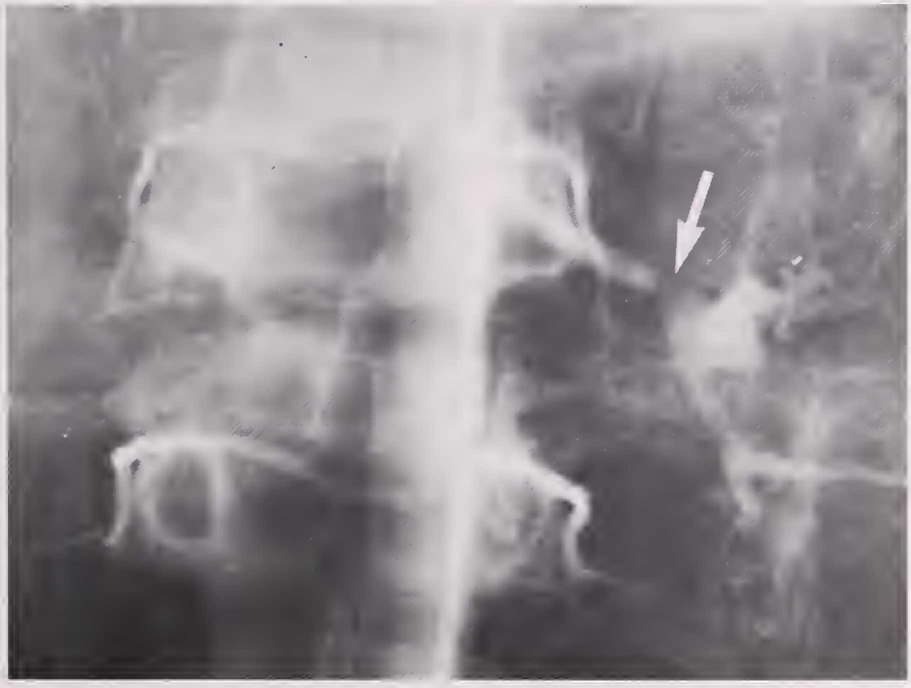

Figure 1
Abdominal Aortogram with arrow indicating small occluded left renal artery with poststenotic dilatation.

operative Study on Renovascular Hypertension[12] provides a number of characteristics of this disorder. A family history of HTN may be elicited in 46% of cases. Fundoscopic changes are present in only 15% of cases. An abdominal bruit is highly suggestive, but present in less than half of these patients. The rapid onset of HTN suggests a renovascular lesion[13] and there may be complaints of headaches, lassitude, nausea, vomiting, polydipsia, and polyuria. Infants may show a picture of failure to thrive. Makker and Lubohn[14] report that undetected HTN in infants may progress to congestive heart failure, respiratory distress, and convulsions.

To make the diagnosis of a renovascular cause of a child's elevated blood pressure, one must first have a high index of suspicion. If the history and laboratory evaluation does not suggest a glomerular parenchymal cause and if one can rule out endocrine causes, such as Cushing Syndrome, pheochromocytoma, exogenous cortisone therapy or congenital adrenal hyperplasia, then consideration should be given to vascular lesions. Coarctation of the aorta should be considered if pulses and pressures in the upper and lower extremities differ. If a renovascular lesion is suspected, an intravenous pyelogram is obtained. Although reported to be falsely normal in up to 60%[15] positive findings are strongly suggestive of renovascular pathology, with a false positive rate of only 10%. Characteristic findings are: 1) a discrepancy in the lengths of the renal capsules (>0.5 cm in children under 15 years and >1.0 cm in those over 15 years), 2) a difference in the relative concentration of contrast within each kidney, 3) differences in excretory time of contrast into the ureters, and 4) notching of the ureters.[16] However, the diagnostic procedure of choice is arteriography with the demonstration of the type of lesion (occlusion, stenosis, aneurysm) and its site as well.

Supportive diagnostic evidence as well as prognostic value can be gained when arteriography is coupled with venous sampling for renin activity. When comparing renal vein renins, if the ratio of the affected to the normal side exceeds 1.5:1, this indicates the patient will probably benefit from surgery or vascular reconstruction.[5,17] A normal ratio may be obtained in some instances when arteriographic evidence shows a lesion and the reverse may occur as well. Schamberlain and associates[18] report that of 9 patients with proven segmental renal artery pathology, 5 had normal renin ratios. This was presumably due to a dilutional effect as excessive renin was being produced only by the area of parenchyma supplied by the involved segmental artery. With redirection of the catheter tip to the involved segment, ratios greater than 9.5:1 were found. Our patient's ratio was 4.12:1 indicating excessive production of renin from the left kidney.

In children, fibromuscular dysplasia accounts for 95% of all renal artery stenosis, whereas in adults the major cause is atherosclerosis.[19] Concentric or eccentric renal ostial stenoses occur in nearly 50% of cases. These proximal lesions, within the intitial 1 cm of the renal artery, are characteristically found in patients with neurofibromatosis fibrodysplasia or abdominal aortic development anomalies. Midarterial lesions and segmental artery stenoses each represent about 20% of cases seen. These are most commonly due to fibromuscular dysplasia. In children, fibromuscular dysplasia has been found to affect the left renal artery more often,[20] whereas in adults right sided lesions are more frequent.[21] Bilateral involvement is not uncommon with some estimates as high as 40%.

Percutaneous transluminal dilation of renal occlusions has recently been popularized in a number of studies as a nonsurgical treatment of fibrodysplastic, atheromatous, or transplant renal artery stenosis.[22-26] Patients are considered cured if following angioplasty and without antihypertensive medication, their diastolic pressure is below the 95th percentile for the child's age and sex, and considered improved if pressures decreased 15% from pretreatment levels, or if they are normotensive while taking medication. A failure is defined as no change in pressures. Although experience in children is limited, most studies of unselected populations report a 90% success rate (cured or improved) with cure rates of 50-80%.[19,22] In those patients requiring medication following unsuccessful or marginally successful angioplasty, the angiotensin-converting enzyme inhibitor captopril may be the drug of choice as good results have been seen with its use.[27]

Patients with fibromuscular disease of the main or branch renal arteries are the most suitable candidates for angioplasty. Those with ostial lesions or atheromatous disease have a lower success rate (25%). Recurrence following angioplasty has been reported to be 5-20%,[22] with the higher rates occurring in patients with atheromatous disease. Complications are infrequent with angioplasty.

Nephrectomy or vascular reconstruction have long been the most common surgical interventions in the management of renal occlusive lesions. Lawson considers nephrectomy to be an unacceptable option in the treatment of these patients unless blood pressure cannot be controlled by other means.[28] The removal of a kidney, especially when a segmental renal artery may be involved seems to be a drastic step, and places the child at future risk. In cases of failed segmental angioplasty, partial nephrectomy may be considered. In addition, vascular reconstruction has been successful in managing patients with renal occlusive disease. Revascularization by saphenous vein graphs, limited at one time due to the small size of a child's vein, is now more widely used due to improved surgical technique. Reimplantation may be the procedure of choice in ostial lesions due to the lower success rate of angioplasty and the fact that a full length of renal artery will allow its mobilization and aortic reimplantation beyond the site of disease. However, new angioplastic techniques may increase the success rate of these proximal lesions. The lower morbidity, mortality, and shortened length of hospitalization would then favor angioplasty.

Summary

It is extremely important to monitor blood pressure in the pediatric population; patients should have their blood pressure taken by experienced personnel at each visit to a physician's clinic. Renovascular disease is a significant cause of pediatric hypertension. Although blood pressures in children have a tendency to be labile, when pressures are consistently elevated above the 95th percentile on repeated examinations, consideration should be given to renal artery lesions. Percutanteous transluminal dilation of affected renal arteries promises to be an effective means of managing patients with renovascular occlusive disease.

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Secondary Amenorrhea in the Female Athlete

THE literature, both lay and professional, has shown a sudden surge of articles regarding physical conditioning, suggesting an increased awareness of our health and fitness. The days of soft and curvy women have been replaced with sinewy, lithe, athletic figures. To be in condition is not only healthy, it is sexy. Yesterday's cheerleaders and spectators are being replaced by dedicated and disciplined athletes with tremendous determination and drive. There are approximately 22 million exercising women in the USA; greater than 6 million women are running and 1 million girls play soccer.[1] Not only are women becoming more active in sports, but they are beginning at a younger age. One third of all junior and senior high school athletes are females actively involved in swimming, gymnastics, cross country, track and field, basketball and dancing. Others are jogging enthusiasts, aerobic dancers, and even marathoners. Women of all ages are buying workout books by the thousands, watching Richard Simmons, Kathy Smith and Jack LaLane each morning and joining health spas in record numbers. Emphasis seems to have switched from diet alone, to that of total commitment to diet and exercise.

We as physicians not only have to deal with the "new image" female but also with increasing numbers of complications which accompany this strenuous routine. It is estimated that there are 4.4 million oligomenorrheic athletes. This paper will discuss the problems of secondary amenorrhea related to exercise, its long term effects on future fertility, as well as its effects, whether protective or destructive, on bone. To begin, here are a few definitions:

Athlete - Anyone who exercises regularly whether competitively or not.

Primary Amenorrhea - Failure of menstruation to occur by age 16.

Secondary Amenorrhea - Cessation of menstruation for six months or three cycles, after having previously menstruated.

Oligomenorrhea - Infrequent, irregular episodes of bleeding usually occurring at intervals greater than 40 days.

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The three basic areas that predispose the female athlete to secondary amenorrhea are physical, hormonal and psychological.

— Physical Factors —

The age at which training began has some long term effects. Frisch et al.[2] questioned 38 college runners and swimmers about when their training began and their age of menarche. They found that those athletes whose training had begun before menarche had a mean age of menarche of 15.1 ± .05 years, whereas there team-mates whose training had begun after menarche had a mean age of 12.8 ± 0.2 years. This is similar to controls and the general population. Their conclusion was that each year of training before menarche, delayed menarche by five months (0.4 years). Of the premenarche - trained athletes, 61% had irregular menstrual cycles and 22% were amenorrheic, whereas 60% of the postmenarche - trained athletes had regular menstrual cycles and none were amenorrheic. A survey of 89 ballet dancers reported by Frisch et al.[3] demonstrated that 10% had primary amenorrhea, 30% secondary amenorrhea, 30% had irregular cycles and 33% had regular cycles. They also noted that the average age training began was 7.4 years and the mean age of menarche was 13.7 years, the norm being 12.7 in college controls.

There also seems to be some relationship to parity and irregularity. Dale et al[4] suggests a relationship between prior pregnancy and subsequent development of oligomenorrhea.

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He found that 50% of their runners who had never been pregnant were oligomenorrheic, while only 20% of runners in the same group with a history of pregnancy were oligomenorrheic. Their hypothesis is that hypothalamic maturity, demonstrated through pregnancy, decreases the susceptibility toward oligomenorrhea.

Changes in percent of body fat and weight loss have a definite effect not only on onset of menstruation but also on regularity. Frisch and McArthur[2] maintained that at least 17% total body weight must be fat in order to initiate menarche and 22% body fat is required to sustain a normal menstrual pattern.

Sixteen women at the University of Arizona were followed through endurance training. A significant loss of body fat occurred with no change in body weight as mean miles per week were increased. Eighty-one percent (13 of 16) developed irregular menses although none became amenorrheic. At the University of New Mexico the incidence of oligo/amenorrhea is 12% among athletes and only 3% among non-athletes. All females running more than 55 miles per week and weighing less than 100% of ideal body weight are amenorrheic. The lighter the athlete, the more trouble with menses. Most of the oligo/amenorrheic athletes who weighed less than 55 kg had not menstruated in one to six years.[5]

— Hormonal Factors —

In four groups of athletes Schwartz et al[6] determined serum levels of luteninizing hormone (LH), follicle stimulating hormone (FSH), thyroid stimulating hormone (TSH), androstenedione, testosterone, estrone, estradiol and dehydro-epinandrosterone. These groups included long distance runners (30 miles per week) and middle distance runners (5-30 miles per week) with regular menstrual cycles, amenorrheic runners, and normal controls. Blood samples from subjects with regular cycles were drawn during the early follicular phase of the menstrual cycle (days 1-7). They found that LH levels were significantly higher in the amenorrheic runners, TSH levels were lower, and basal steroids did not differ; however, the ratio of estrone to estradiol was significantly higher. They also found a higher serum testosterone, but this was well within the normal range. These alterations may result in chronic anovulation, dysfunctional bleeding, or both.

Shangold, et al,[7] found that there is a significant increase in prolactin after exercise. It is also know that there are intermittent elevations of prolactin in lactating women, of which both, effect menstruation. The report, of Colt, et al,[8] showed that running stimulates the secretions of Beta-endorphins, Beta-lipoproteins and adrenocorticotropic hormone (ACTH) Vrbicky, et al,[9] at Creighton University have shown a preovulatory peak of B-endorphines in the normal ovulatory menstrual cycle. It has also been shown that B-endorphins inhibit the secretion of the gonadrotropins LH and FSH. Fishman et al[10] demonstrated that as the percent of body fat decreases, estrogen metabolism shifts from 16-hydroxylation to 2-hydroxylation, (cathechol estrogen). Adashi, E., Karoff, S., et al,[11] have shown that cathechol estrogens decrease LH in women leading to oligo/amenorrhea.

In patients treated at methadone clinics, it is noted that 95% reported regular cycles before methadone or heroin and only 30% had normal cycles while on methadone or heroin.[12]

— Psychological Factors —

Much has been said about physical and hormonal influences on menstruation. However, individually or combined, these factors can not account for all cases of oligo/amenorrhea. Perhaps the pressures and stress of an exercise regimen might contribute to the problem.

Many runners seemed to indicate that one of the most significant factors that motivated them to carry out this very strenous, dedicated and disciplined routine was the "high", or if you will "inner peace", they feel while they run.[13] Many indicate they couldn't make it through the day without running. These runners, although getting much relief from running, have to deal with the stress and pressures of trying to work their running routine into an already busy schedule. Shangold, et al,[1] indicated that many runners have a type A obsessive - compulsive personality. They questioned runners in the 1979 New York marathon and found an extremely success-oriented group. Seventy-seven percent had college degrees and 41% had graduate or professional degrees.

Nonathletic women in stressful situations have an increased incidence of oligomenorrhea/amenorrhea. At the U.S. military academy Shangold, et al,[14] found that 14% of the class of '76 or '77 had irregular periods on admission; but they found that the incidence of amenorrhea at 1 month was 73%, 6 months was 41%, 12 months was 20% and 15 months was 7%. Drew and Stifel[15] studied 402 women entering religious life. Twenty-two percent had a sudden onset of amenorrhea and 10-16% had secondary amenorrhea during the first year.

Much has been said in the lay press regarding anorexia nervosa and its effects on menses. Smith[16] found a similar situation in young athletes. Significant physical exercise, a necessity for strict body control, striving for artistic and technical proficiency, and the consequent preoccupation with the body, together with stressful pressures to compete or attain a level of competency, are similar to the patient with anorexia nervosa. Athletes are rigidly self-disciplined and perfectionistic. Training schedules, conditioning routines, and maintenance of equipment are compulsively regular. This behavior is reinforced by parents and coaches. The athlete, however, usually responds very quickly to counseling, perhaps because their stresses are generally short-term and not as deep seated as in the anorexic patient.

— Bone Loss —

Amenorrhea in the female athlete as noted is a multi-factorial problem. Chronic physical and psychological stress may produce either hypoestrogenic anovulation, euestrogenic anovulation or a combination. Low estrogen levels may result from either inadequate gonadotrophin stimulation to normal ovaries or inadequate ovarian responsiveness to normal or increased gonadotrophin stimulation. Smith[17] states that bone loss occurs at 1% per year beginning at ages 30-35. From the menopause, (a low estrogenic state), until 5 years after the menopause, bone loss of 2-3% per year occurs. Klibanski et al,[18] documented loss of bone density in young women who had elevated prolactin and hypoestrogenic amenorrhea. The loss of bone density in these women was similar to what is seen in the post menopausal female. The implication was that with a low estrogen state, there will be loss of bone density whatever the woman's age. A Seattle research team studied 14 amenorrheic runners and rowers whose average age was 25, matching and comparing them with 14 normally menstruating athletes. Mineral densities in lumbar vertebrae of the amenorrheic women were similar to those in women over age 50. Since physical activity has been shown to inhibit and even reverse bone loss in the post menopausal woman, the investigation was made on the assumption, that intense training regimens would protect athletes against decreases in bone density. This was not the case. They report that dual photon absorptiometry to measure mineral content in vertebrae L1-L4, where trabecular tissue makes up 50-60% of the bone, showed clearly lower mineral density in the ammenorrheic women than in the controls: 1.12 vs 130.9 gm/cm.^{2} Their conclusion was that the amenorrhea that is observed in female athletes may be accompanied by a decrease in mineral density of the lumbar vertebrae rather than a protective effect.[19]

— Recommendations —

An ever increasing number of women, both young and old, are entering athletics. It is extremely important that we approach our medical workup of the athlete in the same manner as with the nonathlete. Particular attention must be placed on any history of menstrual changes. One should discuss training habits and any weight loss. It is also important to determine whether pregnancy or even menstruation is desired. Definitive treatment, if pregnancy is desired, must include a change in habits, perhaps not complete elimination of exercise, but surely some reduction in miles per week. Due to the effects of amenorrhea on bone loss, Speroff, et al,[5] recommend estrogen replacement for the hypoestrogenic female, using 1.25 mg of conjugated estrogens day 1-25 and 10 mg of progestational agent the last 10 days of therapy (i.e. 16-25). These recommendations are based on the results of hormone replacement therapy in the treatment of postmenopausal osteoporosis, where estrogen prevents further bone loss. To date there have been no studies showing that hormone replacement therapy will prevent the loss of mineral density of the lumbar vertebrae in amenorrheic athletes. There are, however, ongoing studies attempting to answer this question.

Of major concern are the long term effects of strenuous exercise. Most exercise induced amenorrhea reverses when training is reduced. Ericksson, et al,[20] found in a ten year retrospective study that the future reproductive capacity of female athletes was completely normal. This indicates that if pregnancy is desired, reduction of miles run per week may be all that is necessary for menses to return. As pointed out by Speroff, L., Shangold, M., Dale, E.,[1] this exercise routine is a very important part of their lives and to stop completely could be devastating, both physically and mentally.

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Presenting Problem and Depression in a Rural Family Practice

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DEPRESSION screening has become a frequent topic of discussion in ambulatory care. Not only have there been disagreements about the best method of screening for depression,[1] but the evaluation and treatment of patients who screen positive for depression is also controversial.[2] At the present time there continues to be a need for evaluating better screening questionnaires. A good screening instrument should evaluate for a specific diagnosis for which treatment is indicated. It should be an instrument which has few false negatives as a primary consideration with false positives a secondary consideration. Most currently available self-report questionnaires use the model of a continuum of severity for depressive symptoms. However, the current method of diagnosing psychiatric illnesses, as spelled out in the Diagnostic and Statistical Manual-Third Edition (DSM III), is based on a criteria system rather than a continuum based system.[4] This criteria based approach is used for diagnostic consideration and continuum systems, such as the Beck Depression Inventory and Hamilton Depression Rating scales, are used more properly in evaluation of symptom severity and for treatment response. In the current multicenter project a DSM III based self-report inventory and an accompanying physician interview are being tested for evidence of reliability and validity. The advantage of a DSM III based screening instrument is that the questionnaire screens for criteria of a major depressive disorder which has a growing research data base and presents physicians with valuable information on treatment modalities. Although the final studies are not complete on the DSM III based self report questionnaire, the preliminary information reveals good correlation between patient self report questionnaire, physician questionnaire and previously well established research methods of diagnosing depression.[5] Estimates of severity of depression correlated well with the Hamilton rating scale, which is the most widely researched physician interview rating scale for depression.[6] The self-report questionnaire has the advantages of ease of use, as well as resulting in a symptom severity score and determining if criteria for major depressive disorder is met.

The exact role of screening in a primary care setting has not been well-defined. It does not seem feasible to screen all patients coming in to a busy primary care setting. Various authors have evaluated ambulatory patients presenting for care and determined high risk groups which are more likely to be depressed. High risk groups have included patients with chronic illness, chronic pain patients, and cancer patients.[7,8] Specific complaints of fatique, sleep disturbance, and nervousness have also been implicated as frequent presenting complaints of depressed patients.[9,10,11] This project was designed to determine the incidence of reported symptoms consistent with major depression. In addition presenting problem information was obtained to determine high risk groups which might benefit most from a selective screening approach.

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Methods

200 patients from the Family Medical Center in Geneva, Nebraska were given the DSM III based self-report questionnaire over a 4 month period from March 1984 to June 1984. This rural primary care clinic is representative of a rural practice in the midwest with most patients in the surrounding communities seeking local family physicians for primary care needs. The average age of the sample was 43.6 years with the male average 47.9 years and the female average 42.2 years. The questionnaires were filled out before the patient's scheduled office visit. The patient's age, presenting problem, and sex were recorded by a physician or nurse familiar with the patients visit. The person completing the patient data was unaware of results of the screening questionnaire. Following completion of the 200 questionnaires the presenting problems were placed into categories by another physician blind to the results of the individual's questionnaire. Categories were designed to form groups of patients with similar illnesses or symptoms grouped by organ system. Such classification was considered useful to aid physicians in considering which presenting problems may most likely benefit from depression screening and evaluation. For example the chronic illness category included patients being seen for routine followup of diagnosis such as hypertension, diabetes, arthritis, and cancer. Ear, nose and throat symptoms were separated into those consistent with an upper respiratory infection and those not related to infection. A health care maintenance group was composed of patients presenting for insurance physicals, routine physical exams and female patients presenting for annual gynecologic and pap exams. Following categorization, the patients questionnaire was scored with depression being diagnosed if the self-report form contained criteria for depression as spelled out in DSM III. Results were then analyzed by the Chi-square method to determine significant differences between each category. Categories containing 8 or more patients were used for statistical analysis.

Results

The sex, age, and positive depression screening results are presented in Table 1. The patient profile of 2.7 female visits for each male visit is consistent with the long term sex ratio of patients for this clinic. There did not appear to be a significant percentage sex difference in report of symptoms consistent with a major depressive disorder.

Table 1

Characteristics of Sample Population and Results of Depression Screen

Sex	Total Screened	Number Positive	Percent Positive
Male	54	10	18.5%
Female	146	28	19.2%
Total	200	38	19.0%

Nine categories were developed, each with at least 8 patients, for a total of 150 patients; the data is summarized in Table 2. Fifty additional patients had presenting problems which fit in various groups, all of which had less than 8 patients, and are not included in the table because of difficulty in interpreting groups with small sample sizes. The categories are ranked according to percentage of positive (major depression criteria reported) responses in that category. Chronic illness was the only group statistically associated with a higher than average risk, although the patient group with gastrointestinal symptoms approached significance (p=.0734). Routine health maintenance visits and acute pain syndromes, which were usually due to trauma, were significantly less likely to report depression symptoms. The chief complaints of patients with positive depression screens in the categories with higher than average risk are listed in Table 3.

Discussion

The incidence of depression by this screening questionnaire was similar to that described previously in a study which used a structured research interview in a primary care setting.[12] Although only the presenting problem of chronic illness followup was statistically significant, gastrointestinal, genitourinary, and chronic pain complaints were higher than the group mean in positive screening for depression. Such presenting complaints may more likely be associated with depression if a larger sample had been tested. It appears that the patients presenting for health care maintenance and acute traumatic problems have an

Table 2

Presenting Problem and Results of Depression Screen

Category	Positive	Negative	% Positive	P value
Chronic illness	6	5	54.5%	$p<.05$
Gastrointestinal symptoms	6	11	35.3%	NS
Genitourinary symptoms	2	6	25.0%	NS
Chronic musculoskeletal pain	4	12	25.0%	NS
Upper respiratory infection	5	27	15.6%	NS
Ear, Nose, and Throat symptoms	1	7	12.5%	NS
Dermatologic symptoms	1	10	9.1%	NS
Routine health care maintenance	5	55	8.3%	$p<.05$
Acute traumatic pain	0	17	0.0%	$p<.05$

incidence of depression similar to the general population.[12]

Further research regarding our DSM III based questionnaire for screening is ongoing and will provide further validation. Well developed questionnaires for use in primary care educational settings as well as in clinical practice may provide physicians with more opportunity to accurately diagnose major depression. This will then allow primary care physicians to treat a problem commonly seen in an ambulatory care practice.

TABLE 3

Chief Complaints of Patients in High Risk Groups with Depression

Chronic illness	Diabetes	n=3
	Hypertension	n=2
	Cancer	n=1
Gastrointestinal symptoms	Abdominal pain	n=3
	Diarrhea	n=1
	Indigestion	n=1
	Rectal bleeding	n=1
Genitourinary symptoms	Metrorrhagia	n=1
	Post-operative hysterectomy	n=1
Chronic musculoskeletal pain	Low back pain	n=2
	Leg pain	n=1
	Arm pain	n=1

Summary

Two hundred adult ambulatory patients presenting for care at a rural family practice clinic were given a self-report depression questionnaire as part of a multicenter study of a new depression screening tool. The prevalence of depression was 19%. Along with the depression inventory the presenting problem, age, and sex of the patient was determined. Patients who were being seen for routine followup of chronic illness were statistically more likely to report depression symptoms ($p<.05$). Patients being seen for routine health care maintenance and acute pain were less likely to report depression symptoms.

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A Case-Control Study of Diabetic End-Stage Renal Disease in Nebraska

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END-STAGE renal disease (ESRD) is recognized as a frequent complication of diabetes, and studies have determined that 25% of all new cases of ESRD occur among diabetics.[1] At the present time, however, only duration of diabetes, which is a risk factor for every chronic complication of diabetes, and age, which is a risk factor for virtually all chronic disease, can be considered with any certainty to be risk factors for diabetic ESRD.[2] In order to further clarify the etiology of this disease, the Nebraska Diabetes Demonstration Project recently conducted a case-control study of diabetic ESRD.

Methods

a) Study Design

In this study, cases have been defined as diabetics with ESRD and controls have been defined as diabetics without ESRD. Cases were identified from among diabetic ESRD patients reported to the Nebraska Chronic Renal Disease Program during the years 1979 to 1981. This program provides reimbursement to medical facilities for the treatment of almost all cases of ESRD in the State of Nebraska. Controls were identified from one of three sources: from the practices of physicians providing primary care for corresponding ESRD patients, from physicians with patients suitable for matching with cases, and from the records of cooperating hospitals.

Controls were matched with cases according to age, duration of diabetes, and residence in an urban (i.e., metropolitan Omaha and Lincoln) or rural area. Controls were matched by age and duration of diabetes to within five years of each case. Study protocol directed that three controls be matched per case, although this objective was not fully achieved. However, only two cases were excluded from the statistical analyses due to a complete lack of appropriate controls. The study group described in this report consists of 64 cases and 160 controls.

b) Data Collection

Data pertaining to the demographic and medical variables of interest were collected by a medical records specialist (D.K.K.) from the available records of every subject. Records were examined for a period of at least ten years prior to the onset of ESRD among the cases and at least ten years prior to the time of data collection among the controls. Factors for which data were gathered were defined as follows:

Type of Diabetes — The Type I/Type II scheme was used for the classification of study subjects. Physician diagnosis of type of diabetes was required for classification of each subject. Subjects diagnosed as having either insulin-dependent or juvenile-onset diabetes were considered to have Type I diabetes, while those diagnosed as having either non-insulin-dependent or adult-onset diabetes were considered to have Type II diabetes. The records of several subjects failed to include a physician diagnosis of the type of diabetes; these records were reviewed by one of the study investigators (S.M.T.) and classified according to other relevant indicators.

Type of Diabetes Management — Among the cases, type of diabetes management refers to the last regimen prescribed prior to the onset of ESRD. Among the controls, type of diabetes management refers to the regimen followed at the time of data collection. Subjects using insulin alone or in combination with diet and/or oral hypoglycemic agents have been classified as insulin users, while those using diet and/or oral drugs have been classified as non-insulin users.

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Family History of Diabetes — Subjects were considered to have a positive family history of diabetes if either an immediate or extended family member was known to have been diagnosed for the disease.

Smoking History — Current and former smokers were classified as having a positive history of smoking. Subjects who had never smoked or for whom smoking information was not available were classified as having a negative history of smoking.

Ketoacidosis — At least one hospitalization for either ketoacidosis or coma was required for a subject to be classified as having a positive history of ketoacidosis.

Hypertension — Hypertension was considered present only if a physician diagnosis of the condition had been made. Date of diagnosis was also noted.

Neuropathy — Neuropathy was considered present if a physician diagnosis had been made or if neurological examination had indicated a reduction in sensation in any extremity.

Retinopathy — Retinopathy was considered present if physician diagnosis had been made or if ophthalmologic examination had revealed either exudates (hard, soft), hemorrhages, microaneurysms, or proliferation.

Blindness — Subjects were classified as blind only if the condition was specifically mentioned as such.

Cerebrovascular Accident — Specific mention of at least one cerebrovascular accident or transient ischemic attack was required for a subject to be classified as having a positive history of CVA.

Myocardial Infarction — Specific mention of at least one myocardial infarction was required for a subject to be classified as having a positive history of MI.

c) Data Analysis

The success of the matching process in eliminating the effects of age and duration of diabetes as risk factors was evaluated by comparing the mean values of these variables in the cases and controls. Age at onset of diabetes, which was not a matching factor, but is obviously influenced by the matching process, was also examined. Differences between the two groups were analyzed using standard t-tests.

The relationship between each of the study variables and ESRD was determined using the Mantel-Haenszel method for matched case-control data with variable matching ratios.[3] Using this method, the association between each variable and ESRD is expressed in terms of an odds ratio. Odds ratios greater than 1.0 indicate a positive association between the variable and ESRD.

Results

Comparison of the cases and controls by mean age, age at onset of diabetes, and duration of diabetes is shown in Table 1. No significant differences between the cases and controls for either age or age at onset were noted, although the age at onset was over three years lower in the cases than in the controls. Comparison of the cases and controls by mean duration of diabetes shows that the cases had had diabetes for a significantly longer period of time than the controls. When broken down by type of diabetes, age and duration of diabetes were greater among the cases versus the controls, while age at onset was virtually identical in both groups. However, when Type I cases and controls were compared to their respective Type II counterparts, duration of diabetes was longer in the Type I subjects than in the Type II subjects.

Table 2 presents the results of the analysis of the matched triplets. The odds ratios for sex (males), neuropathy, retinopathy, blindness, and hypertension were significantly elevated above 1.0. However, causality can not be inferred from the elevated odds ratios associated with neuropathy, retinopathy, blindness, and hypertension, as the dates of onset of these conditions relative to the onset of ESRD were not considered. Utilization of a multivariate statistical technique (logistic regression) as a means to control for the difference in

Table 1. **Comparability of cases and controls by mean age, age at onset of diabetes, and duration of diabetes; in aggregate and by type of diabetes**

	cases (n=64)	**controls** (n=160)
Mean age (years ± SD)	47.8 (±15.4)	48.9 (±16.4)
Mean age at onset (years ± SD)	29.3 (±17.6)	32.7 (±18.3)
Mean duration of diabetes (years ± SD)	18.5 (±6.9)	16.2 (±7.2)*
Type I diabetes	**cases** (n=34)	**controls** (n=68)
Mean age (years ± SD)	37.0 (±10.3)	34.8 (±10.7)
Mean age at onset (years ± SD)	16.6 (± 8.9)	15.9 (± 9.6)
Mean duration of diabetes (years ± SD)	20.4 (± 6.0)	18.9 (± 7.0)
Type II diabetes	**cases** (n=27)	**controls** (n=91)
Mean age (years ± SD)	61.4 (± 8.5)	59.9 (± 10.8)
Mean age at onset (years ± SD)	45.5 (± 12.1)	45.7 (± 11.7)
Mean duration of diabetes (years ± SD)	15.9 (± 7.6)	14.1 (± 6.7)

*p<.05

NOTE: Three (3) cases and one (1) control could not be classifed by type of diabetes.

duration of diabetes between the cases and controls failed to alter the results shown in Table 2.

Table 2. **Association of selected factors with diabetic ESRD**

Cases n= 64
Controls n = 160

	Odds Ratio	**95% Confidence Intervals**
Sex (male/female)	2.40*	1.24, 4.65
Race (non-white/white)	1.56	0.64, 3.85
Type of diabetes (Type I/II)	2.18	0.64, 7.39
Type of diabetes management (insulin/non-insulin)	1.00	0.39, 2.59
Family history of diabetes (some/none)	0.55	0.26, 1.14
Smoking history (ever/never)	0.92	0.39, 2.12
Ketoacidosis (yes/no)	1.48	0.56, 3.93
Neuropathy (yes/no)	8.56*	3.53, 20.79
Retinopathy (yes/no)	11.74*	4.09, 33.72
Blindness (yes/no)	13.03*	3.75, 45.28
Hypertension (yes/no)	23.26*	7.13, 75.90
CVA (yes/no)	1.93	0.61, 6.13
MI (yes/no)	1.81	0.83, 3.93

*p<.05

Discussion

The elevated odds ratio associated with hypertension in these data documents the already proven relationship between ESRD and hypertension. We do not interpret this statistic to mean that hypertension is a risk factor for diabetic ESRD, as the pathogenesis of hypertension during the course of declining renal function is a well-documented phenomenon.[4,5,6,7] However, we also found that the onset of hypertension occurred an average of over five years before the diagnosis of ESRD among the study cases, and this certainly underscores the frequent recommendations for aggressive treatment of hypertension among diabetics. Recent studies have shown that such hypertension control regimens can indeed slow the inevitable decline in renal function which occurs over time.[5,7] In addition, the potential savings in morbidity (hypertension is a risk factor for other diabetes-related complications) and cost (dialysis alone averages about $20,000 annually per patient) could make community-based intervention programs highly cost-effective.

Another study finding of particular interest concerns the elevated odds ratios associated with type of diabetes. The risk of developing nephropathy by type of diabetes has not been quantified to date, as previous investigations have employed study groups consisting exclusively of either type.[4,8,9,10] The risk associated with Type I diabetes in this study failed to achieve statistical significance; the risk would have undoubtedly increased had we not matched for age and duration of diabetes. The increased risk associated with Type I diabetes appears to be tied to the differences in survival between the Type I and Type II diabetics, as evidenced by the fact that the Type I cases had a considerably longer duration of diabetes than their Type II counterparts (20.4 vs. 15.9 years). Most likely, many Type II diabetics, due to advanced age, succumb to non-renal conditions (e.g., cardiovascular disease, cancer) before nephropathy has the chance to develop. Future improvements in the treatment of such conditions could work to increase the number of Type II diabetics who survive diabetes long enough to experience renal failure. However, even in the absence of such improvements, our data show that Type II diabetes already contributes substantially to the problem of ESRD, as over 40% of the study cases were Type II diabetics. The fact that the overwhelming proportion of the diabetic population falls into the Type II category dictates that, in spite of the increased risk associated with Type I diabetes, the absolute number of Type II diabetics with ESRD will be considerable.

Many of the remaining findings of this study confirm the results of previous research. Although duration of diabetes was a matching factor in this study, the fact that the mean duration of diabetes was significantly greater among the cases versus the controls undoubtedly confirms its power as a risk factor for ESRD. Males were found significantly more frequently among the cases than the controls, corroborating the results of a recent follow-up study of Type I diabetics.[9] However, a study of Type II diabetics with nephropathy found females at substantially greater risk than males,[8] while another study of Type II diabetics with nephropathy failed to confirm any association with sex.[10] The data from this study, when broken down by sex and type of diabetes, indicate an increased risk for males in both Type I and Type II diabetes, although more pronounced among the Type I subjects. Smoking was not identified as a risk factor for ESRD, a finding reported in two previous investigations.[8,11] Nevertheless, we would agree with West et. al. that diabetics should abstain from smoking, due to its adverse effects on the heart and peripheral circulation.[11] Race was not significantly associated with ESRD, contradicting reports of increased risk among blacks,[8] although the low percentage of blacks in Nebraska and the small size of the available study group may have precluded the possibility of detecting significant results. Finally, the significantly greater prevalence of diabetes-related complications (neuropathy, retinopathy, blindness) among the cases has been reported in earlier studies of both Type I and Type II diabetics with nephropathy.[4,8,10]

Due to the limitations of our data sources, several factors for which data collection was originally planned had to be excluded from the statistical analyses. Among the variables for which data proved difficult to obtain include obesity (height, weight), socioeconomic status (education, occupation), and the type and success of past diabetes and hypertension control regimens. As all of these factors have been identified as potential risk factors, future studies should make every attempt to quantify these factors in order to more completely determine the etiology of diabetic ESRD.

Summary

These data indicate that males and Type I diabetics are at increased risk of developing diabetic ESRD. The risk associated with Type I diabetes is likely a function of differences in age and survival between Type I and Type II diabetics. In spite of this risk, the large proportion of diabetics of Type II etiology ensures that this group contributes substantially to the problem of diabetic ESRD. The finding that hypertension was diagnosed over five years prior to ESRD supports the advisability of aggressive control of this condition among diabetics, since hypertension control can slow the progress of kidney failure.

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FRACTURE OF THE MONTH

Explosion Dorsiflexion Fracture-Dislocation of the Ankle - an Indication for Closed Functional Traction Treatment

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A 47-year old woman was brought to the emergency room with angulation and deformity of her left ankle after falling approximately six feet from a ladder. She related that she "turned over on top of my ankle" upon landing.

Initial physical examination revealed varus angulation of the left ankle and a 6 cm. soil contaminated wound over the medial malleolus. Dorsalis pedis and posterior tibial pulses were equal on both sides. Sensory and motion examination of the left foot and ankle showed no deficits. Radiographs of the left ankle (Figure 1) demonstrated an open comminuted intra-articular fracture of the distal tibia, a fracture of the distal fibula, and a chip fracture on the medial aspect of the talus. The purpose of this presentation is to describe a closed functional method of treatment for this complication-prone injury.

Discussion:

Distal intra-articular fractures of the tibia— explosion fractures — usually result from a fall from a height or a motor vehicle accident. When the foot is pronated and the ankle is dorsiflexed during axial compression, the talus acts as a wedge against the anterior and medial articular surfaces of the tibia.[2] The result is comminution of metaphyseal bone and articular surfaces leading to anterior dislocation of the talus.

These injuries are the most complication prone of all ankle fractures.[1, 3, 4] Skin sloughing is common with open reduction because of increased soft tissue swelling. Unstable fixation, nonanatomic alignment, infection, and nonunion are frequent sequelae to operative treatment of this injury. Internal fixation is fraught with difficulty and has been described as "pinning a custard pie to the wall". Conversely, closed cast treatment is unsatisfactory because of difficulty in reducing the fracture fragments plus residual stiffness and loss of ankle motion with immobilization.

Goals of Treatment:

The objectives of treatment should be to restore reasonable alignment of the metaphyseal fracture and allow joint motion to maintain the articular space. This can be effectively accomplished for such comminuted, infection prone fractures using traction with joint motion. Movement of the joint is critical in molding and nourishing the articular fragments, while traction maintains alignment of the subchondral bone.

Management:

The patient was taken to the operating room and the left ankle wound was irrigated, debrided and left open. The fibula was reduced and the fixation maintained with a Rush rod to correct lateral displacement. Intraoperative radiographs revealed that the talus still tended to displace anteriorly (Figure 2A). A Steinmann pin was then placed through the os calcis and a Salvatori traction bow with 5 lbs. of traction was applied to reduce the key tibial fragments. This restored normal relationship between the talus and distal tibia (Figure 2B).

The infected wound was again debrided and

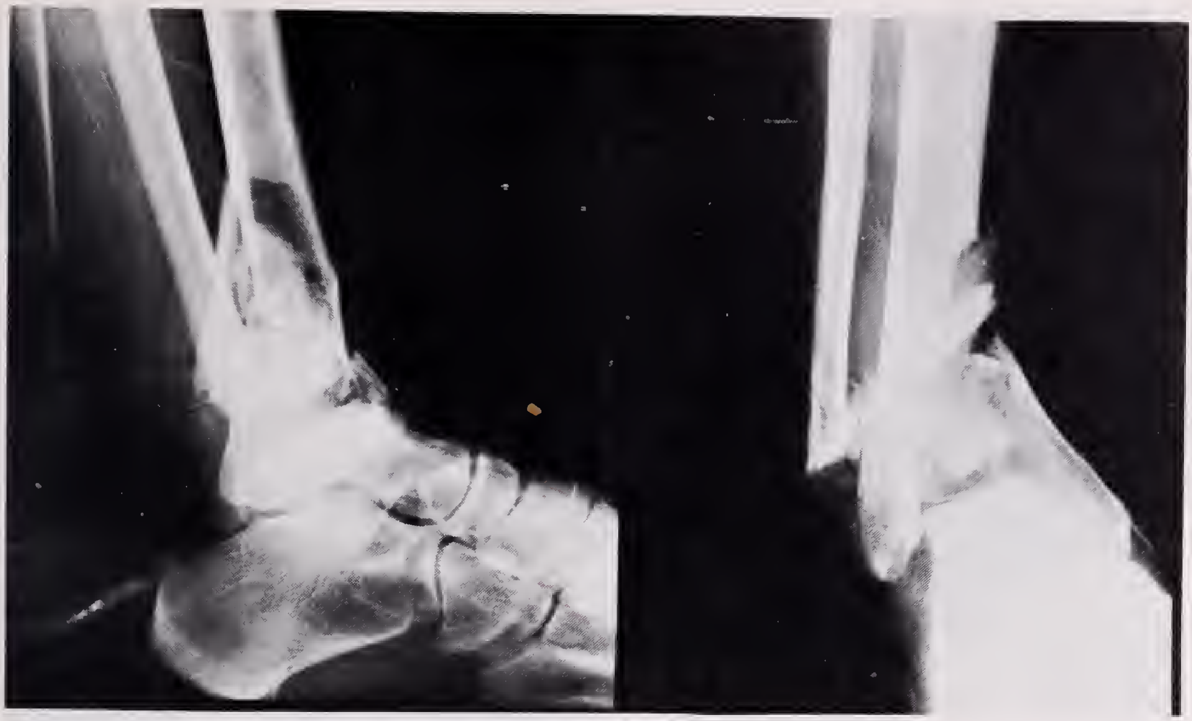

Figure 1A & B
Anteroposterior and lateral x-rays at the time of admission showing explosion dorsiflexion open fracture of the ankle.

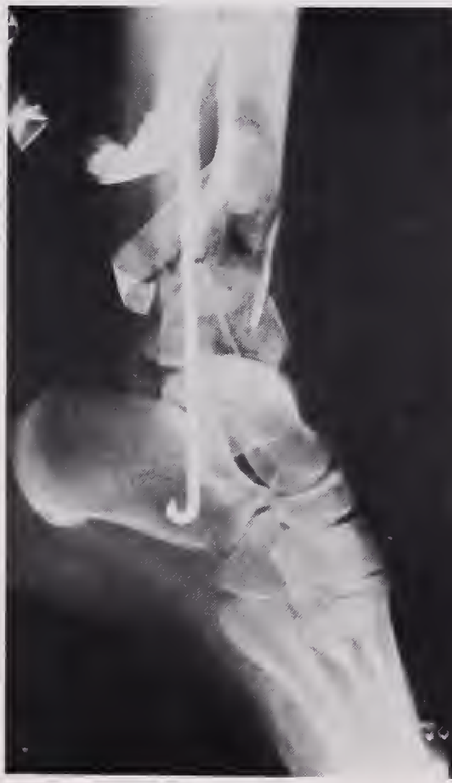

Figure 2A
Intraoperative lateral roentgenogram after Rush pin fixation of the fibula demonstrates the tendency of the talus to displace anteriorly and superiorly.

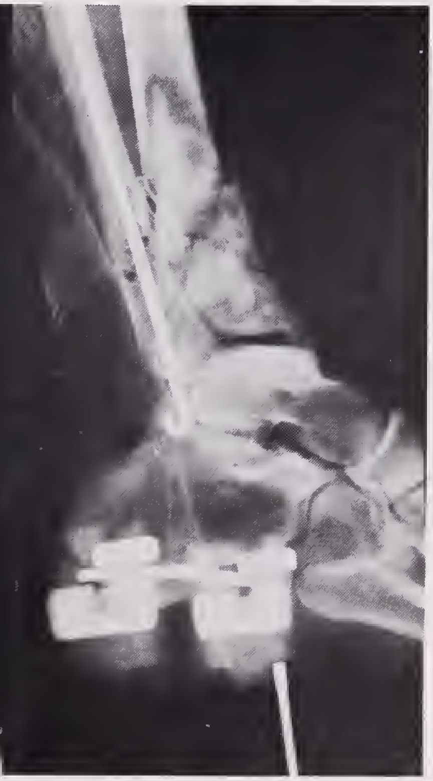

Figure 2B
Lateral roentgenogram showing alignment and restoration of joint space with application of os calcis traction.

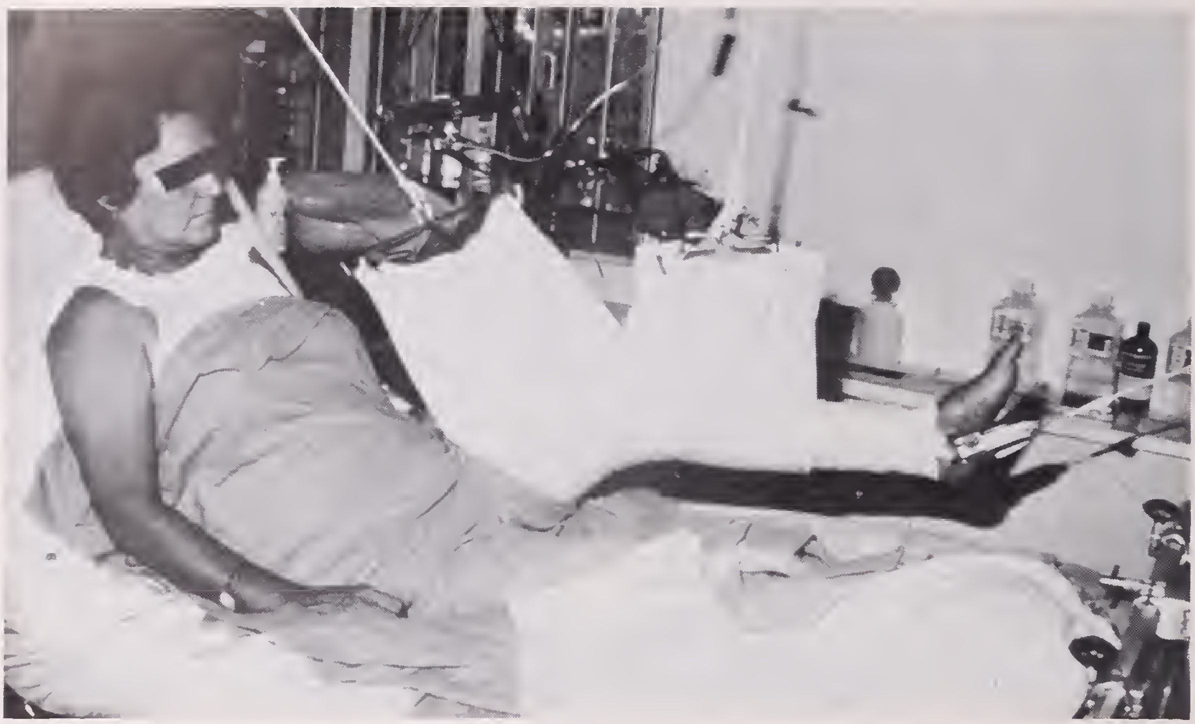

Figure 3
Os calcis traction technique used with the patient in bed and the limb elevated allowed active motion of the ankle while maintaining joint space alignment.

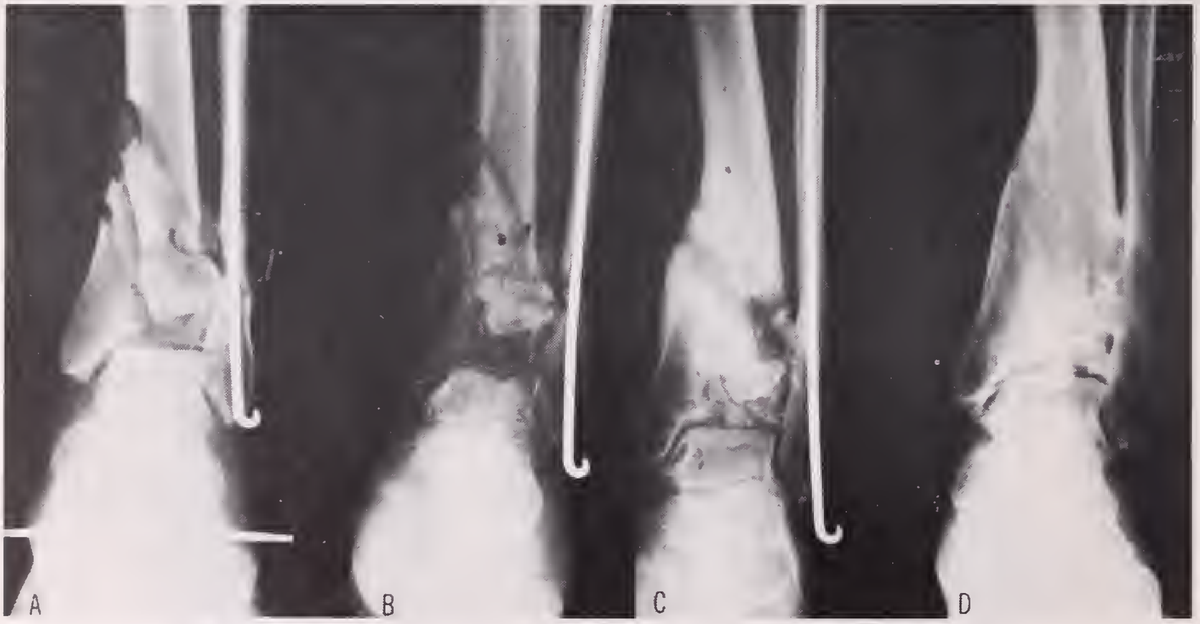

Figure 4A
Antero-posterior roentogenogram with ankle subjected to traction demonstrating maintenance of joint alignment without complete reduction of metaphyseal bone fragments.

Figure 4B
Antero-posterior roentgenogram at time of cast removal 12 weeks post injury shows disuse osteoporosis.

Figure 4C
Antero-posterior roentgenogram one year after injury shows consolidation of metaphyseal fragments without collapse of the joint space.

Figure 4D
Antero-posterior roentgenogram at follow-up four years post injury.

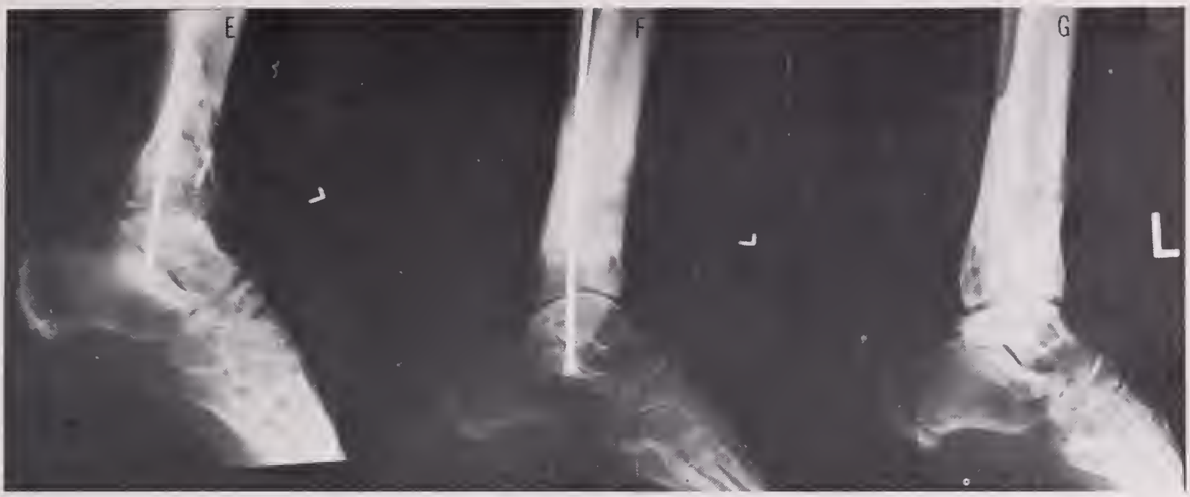

Figure 4E, F, G
Lateral roentgenograms of patient at 12 weeks post injury, one year post injury and four years post injury demonstrating maintenance of joint space.

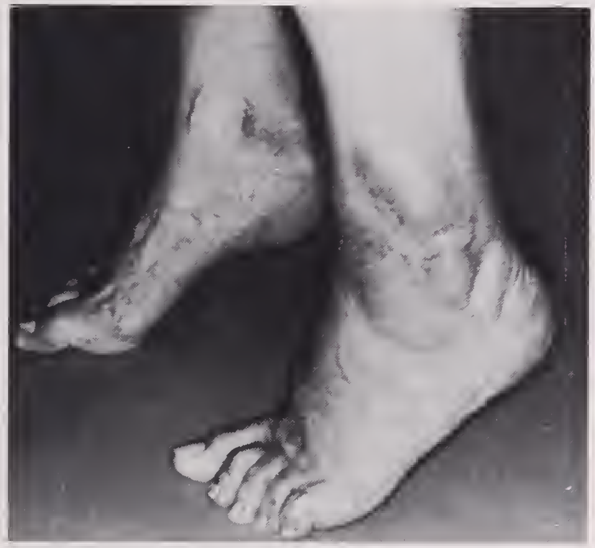

Figure 5
Clinical photograph of the patient's ankles 4 years post fracture demonstrate the ankle wound had headed by spontaneous intussussception. The patient had normal plantar flexion strength and motion. Dorsiflexion however was limited to 10° less than the opposite side.

irrigated three days post-operatively. Initial cultures grew Enterobacter and the patient was placed on appropriate IV antibiotics until the wound closed by spontaneous intussusception. The os calcis traction was maintained for four weeks and the patient was encouraged to exercise the ankle actively in dorsiflexion and plantar flexion (Figure 3). Subsequently, a long leg cast was applied for three weeks followed by a patellar tendon bearing cast for four weeks. The fracture was clinically healed at the end of eleven weeks with no signs of infection. On followup the healing of the metaphyseal fracture progressed and the joint surface did not collapse (Figure 4). At four year followup the patient had no ankle pain and minimal stiffness. Her range of motion in the ankle included plantar flexion equal to the opposite side but dorsiflexion lacked 10° (Figure 5).

The prognosis for this fracture is dependent on the ability to align and repair the articular surface and maintain joint space. Anatomic reduction of the multiple small metaphyseal fragments is not necessary provided these objectives can be achieved. This case demonstrates the advantages of functional traction allowing the patient to exercise the ankle while the fracture heals. Joint motion restores the articular congruity and nourishes the repair of the cartilage fracture. The method is particularly useful for the most severe of these articular fractures. Functional traction treatment has also been proven applicable to the comminuted explosion type fractures about the elbow as well as about the ankle.

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X-RAY OF THE MONTH

Appendicolith

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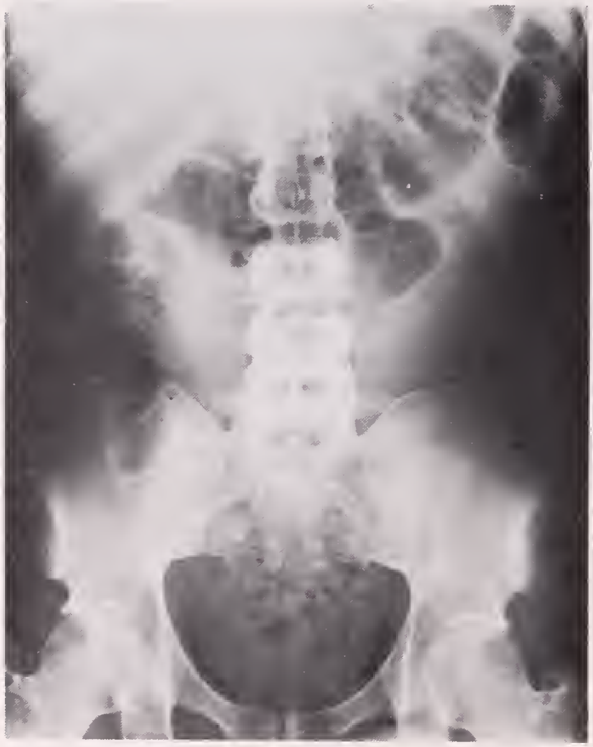
THIS 23 year old black male entered the E.R. with a 14 hour history of diffuse abdominal pain. He also experienced anorexia and nausea but no vomiting. His past history was complicated and he has admitted addiction to both heroin and cocaine, but he successfully "cold-turkeyed" himself 96 hours earlier.

His physical exam revealed mild tenderness in the lower abdomen without rebound. The lab values were not contributory. A supine x-ray of the abdomen was obtained and a 1 cm circular calcification was noted in the region of the right sacral ala.

DISCUSSION

Radiologically detectable appendicoliths are calcified concretions within the appendiceal lumen. The incidence within the normal population is felt to be approximately 1%, whereas in the setting of acute appendicitis, this rises to 10-12%.[1,2,3] Seventy percent of those detected are single; 20% of cases show two; and in 10% of patients three or more are formed.[1]



Appendicoliths have their origin as fecal material inspissated within the appendiceal lumen. This material irritates the mucous glands within the crypts of Lieberkuhn and mucous production is stimulated. The mucous precipitates onto the fecal nucleus forming several concentric layers of varying mineral content. The calculus eventually reaches a critical size at which time pressure atrophy of the mucous glands occurs, halting both mucous production and growth of the stone.

Roentgenographically, the usual appendicolith consists of an oval 0.5 - 2.0 cm radiopacity found within a 15 cm diameter of the midpoint of the right iliac crest.[4] Unusual positions may occasionally be seen as in RUQ calculus with retrocecal appendix or a LUQ stone with malrotation of the gut.[5] Seventy-five percent are laminated; the others are of diffuse or granular calcification.

Appendicoliths are significant because if one is seen in a patient with abdominal pain, there is a 90% chance of acute appendicitis.[1] When an appendicolith is seen in acute appendicitis, greater than 50% of cases are complicated by gangrene or perforation of the appendix — three times the usual number.[1,2,6] Also, several cases have been reported where chance finding of an appendicolith in a normal subject was followed by development of acute appendicitis later from weeks to years.[3,5,7]

The differential diagnosis includes right ureteral calculi, bone islands in the ileum, mesenteric nodes, gallstones (with retrocecal appendix), opaque pills, phleboliths, and calcified appendices epiploicae. These questions are usually readily answered with appropriate studies (IVP, ultrasound) or stereoscopic views.

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Letters to the Editor

Dear Editor:

As a sociologist engaged in ongoing research in Nebraska's gay community I must strongly object to the irresponsible politicization of medical discourse effected by your publishing, in the August issue of **The Nebraska Medical Journal** an article by Paul Cameron and his associates entitled "Sexual Orientation and Sexually Transmitted Disease".

Cameron's homophobic bias, distortions of the social science literature concerning homosexual persons, and violations of professional ethics, are a matter of public record. The questionnaire used by his group in conducting the survey upon which this article was based could be used as a textbook example of how research should not be conducted under any circumstances.

At a time when high risk populations need more than ever to establish a relationship of trust and mutual respect with health-care providers, you have exhibited outrageous ignorance of and insensitivity to their needs. At the same time you have done the disservice to your readers of compounding their medical school-bred ignorance with misinformation. You have left them less capable then ever of understanding their patients' sexuality.

By definition, a study of human sexuality conducted in the United States at this particular epoch in our history which ignores the realities of social desirability response and stigmatization is scientifically worthless. In choosing to legitimate false conclusions distortedly induced from faulty data obtained through an instrument consciously designed to distort response you have inadvertantly 1) exposed your editorial board as completely incompetent to assess social science survey data, and 2) raised serious questions about the capacity of the medical profession in Nebraska, in its current mode of social organization, to deal intelligently or effectively with the very real dangers posed to the state's population by retroviral mutability and diffusion.

Resignation by those members of the editorial board responsible for this outrage would be an appropriate start to ameliorative action.

Very truly yours,

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* * *

Dear Editor:

In its August issue, **The Nebraska Medical Journal** published an article by Dr. Paul Cameron **et al.** Entitled "Sexual Orientation and Sexually Transmitted Disease," it summarized the results of a survey conducted in five American cities. Loaded with numbers and statistical jargon, the article appeared to be a dispassionate, scientifically objective analysis of homosexual and heterosexual practices. The survey might have had some credibility if it had been undertaken by non-partisan medical or behavioral scientists. Unfortunately, the survey was initiated and sponsored by ISIS (Institute for the Scientific Investigation of Sexuality), a group openly hostile to homosexuals. Its Chair, Dr. Paul Cameron, has published numerous pamphlets on homosexuality, "documenting" its link to mass murder, child molestation, and other anti-social activities; claiming to protect the public, he has recently called for the quarantining and possible execution of all homosexuals.

In the **NMJ** article, the authors stated that "the questionnaire was too extensive to reproduce here." One wonders whether it was length or the biased and offensive nature of the questions that prevented their inclusion. For example, in question #21, the authors asked: "With how many **homosexual** virgins have you had homosexual relations?" The reader cannot help but wonder how many people ask that of their sexual partners. For question #3, which asked the respondent how they felt about sharing toilet facilities with a homosexual, the first answer of five that they could have selected was: "very positive, I'd enjoy it greatly." The flippant, almost comical tone of this and other items might have discouraged serious respondents from participating in the project.

Another equally important flaw in the questionnaire was the lack of operational definitions. People were asked in #51 whether others had made "serious sexual advances" to them. Since "serious sexual advances" was never explained, one person might have interpreted such acts to include winking, another to include verbal innuendos, another to include fondling. Question #32 asked: "Have you ever been **committed** to a homosexual relationship (been homosexually "married")? A positive answer was impossible to this question, given that homosexual marriages are legally unrecognized in all states. Yet what would the authors infer from the responses—that gay people are incapable of serious relationships?

The authors acknowledged that the majority of people given surveys did not return them. One must therefore question the representativeness of the sample. The authors admitted that "our sampling method was somewhat biased soliciting homosexuals" and "it is our impression that sexually conservative people were more apt to refuse to cooperate." One might add that the stigmatization of homosexuality, and the suspected fear of public disclosure, might have further reduced the number of conservative people who cooperated in the survey. This suggests that responses were skewed in favor of "kinky" sexual behaviors. Something else the authors failed to mention was the following sentence, which was printed in the questionnaire's preface: "This survey will be put to a number of significant legislative and judicial uses." With the obvious anti-gay bias of the questionnaire, any person could have inferred his/her responses might be used in a way damaging to gay people. This would have motivated homophobes to participate in the survey and gay people to avoid it.

If the authors were unknown in Nebraska, one might understand the editorial board of **NMJ** accepting the data in good faith. However, the article's primary author, Dr. Cameron, is well-known for his prejudicial statements against gay people. He was Chair of the Committee Opposed to Special Rights for Homosexuals, which helped defeat Lincoln's gay civil rights referendum. He has appeared on **Crossfire** and the **CBS Nightly News,** attacking gay people as socially dangerous, and had his survey data prominently reported in Lincoln and Omaha newspapers. This hardly qualifies him as an objective researcher on the subject of homosexuality.

Others within his own profession, psychology, have had similar reservations about Dr. Cameron. In 1984 the American Psychological Association expelled him for unethical conduct, and the Nebraska Psychological Association has repeatedly rebuked him for misrepresenting research in the area. Other social scientists, such as Dr. Alan Bell of the Kinsey Institute (whom Cameron respects enough to cite in his article) and Dr. A. Nicholas Groth, have been so concerned about the misinformation Cameron publishes that they have either publicly criticized him or have filed complaints with the State Board of Examiners. Yet the editorial board of the **NMJ**, ignoring the long history of Cameron's biased involvement with homosexuality, chose to publish his article as a piece of objective, scientific research.

I hope, if nothing else, some of the points raised in this letter prompt you to think about the consequences of publishing such material. It enhances the authority of bigots who represent themselves as experts, and inflames public opinion against homosexuals, who are the targets of increasing hostility within this country.

Sincerely yours,

Scott Stebelman

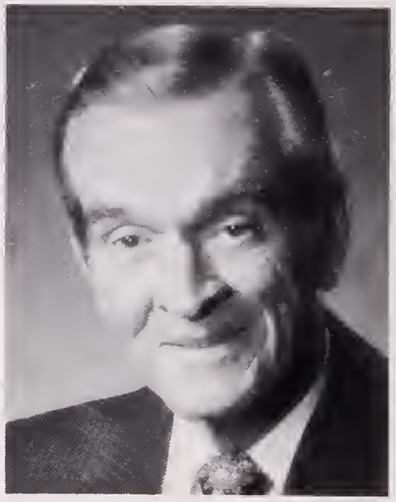
President's Page

PROFESSIONAL LIABILITY

The medical profession is attempting to navigate its ship through a tempestuous sea full of hidden rocks and shoals in the form of regulations and constraints while the entire area is infested with hungry barracudas representing our adversaries in the field of professional liability. This phase of liability came into prominence in the post World War II era and has grown to such monstrous proportions the very vitality of the profession is threatened.

The present day mentality of suing someone on the slightest whim has become a part of the health care scene. The costs which are borne by the patients have reached astronomical levels. Premiums for liability policies have reached six digits for various specialists in some states causing some to locate their practice elsewhere, while also keeping younger physicians from starting a practice in these areas. Physicians practicing obstetrics will soon be in short supply or non-existent in some states if this continues. In New York, 16% of OB/GYN specialists have ceased obstetrical practice, 23.3% have stopped in California and 25% in Florida have done the same. A number of physicians doing obstetrics in Nebraska are considering stopping this phase of their practice. The awards handed out are increasing in volume and size, occasionally reaching the multi-million dollar level, causing many insurance companies to stop writing policies as their fiscal stability weakens making it very difficult for some physicians to obtain any insurance. The cost defending any case has increased and in some instances reaches $20,000.00 for the mere filing of a frivolous case. Defensive medicine now being practiced contributes greatly to the cost. By one estimate, $15-40 billion per year, another estimates 25%-50% of all treatment, is for defensive medicine.

There are important messages in this brief review for both patients and physicians. Patients should be made aware they are bearing the brunt of these costs. Less than 50% of the award dollars handed down to them will find its way into their pockets. Plaintiff attorneys stand to profit in filing a nuisance case having no merits while hoping the defendant will settle quickly to avoid further time and expense. Patients should be made to understand the difference between negligence and imperfection. Results in medical management which are less than perfect or desirous do not necessarily mean negligence.



Francis D. Donahue, M.D.

Physicians should respect the rights of patients to seek redress in cases of obvious negligence, and we should never lose sight of our responsibility of professional discipline.

The AMA has underway an ambitious effort to combat this problem, and the NMA through its Ad-Hoc Committee on Professional Liability is putting together a program which hopefully will bring some order to this chaotic condition. The legal profession, which controls much of the 3 branches of the Federal Government, may make progress difficult, but an all-out effort must be made.

An enigmatic aspect of this problem presents a medical profession delivering a quality of care unanimously agreed to be the finest the world has ever seen yet its very existence is being threatened by these actions. Both government and business are consumed with the need to reduce cost even to a point of lowering the quality of care in the process, yet they appear blind and unconcerned about the staggering costs generated by this senseless debacle.

Francis D. Donahue, M.D., President

The Auxiliary

PRESIDENTIAL MESSAGE

The day my husband graduated from medical school was one of the proudest days of my life. Being installed as President of the Nebraska Medical Auxiliary was also a very proud moment for me, and one I will always cherish.

Helen Keller said "There isn't anything a person can't accomplish if they keep at it long enough." We auxilians have a real challenge to face. We must help our husbands respond to changes in medicine today. Pressure is on through competition for patients, cost containment, alternate delivery systems, government involvement, hospitals competing for patients and the constant threat of a law suit, just to name a few.

To accomplish the challenge we must become knowledgeable about the issues, and be actively involved in legislative action.

Ardis Grace

Public opinion of the physicians image is an area that needs some real concentration. Billie Brady quoted Joseph Boyle, M.D., past AMA President in her message to everyone at the state convention. Mrs. Brady says, "fewer than three of every 10 people believe doctors charge reasonable fees, two out of 10 think doctors are trying to hold down costs, four out of ten believe that doctors spend enough time with them and the final blow that four out of every 10 think doctors act as if they are better than other people." We must help to convince the people that physicians are not self-serving, but have dedicated their lives to help others. As Billie Brady said, "We can do no less today than build upon our 60 year heritage of serving the health needs of our communities, and unite in a common bond of pride and common goals to meet the challenge facing us."

In her address at the 1985 AMA Auxiliary Convention, our new national auxiliary president Mary Kay PcPhee listed her shared goals to be the three C's, COMMITTMENT, CONCERN and COOPERATION. She reminded us of the grave crisis medicine faces today, and that we must be aggressive and lead.

In his first message through the AMA Journal as state president, Dr. Francis Donahue says "If we don't protect and preserve our standards, no other groups would or could be capable of doing it." He reminded us that quality of medicine comes first.

My personal goals are to promote our only AMA philanthropic endeavor, AMA-ERF, to support AMA approved legislation, to recruit and retain members, to encourage Health Gallery progress, and to urge each county to have a project of some kind for NMF. HEALTH PROJECTS will be my major thrust for the year, and I ask for your help in getting involved with education for Early Detection of Colorectal Cancer. I challenge you to help raise the 45% figure of lives being saved to 75% and more through education. My husband, Les, was interviewed by the editor of our Blair Memorial Community Hospital newsletter recently and was asked why he liked family practice. He replied that he liked to take care of the whole family, Mom, Dad and kids. This prompted my these of HEALTH FOR THE WHOLE FAMILY. Shirley Johnson (Mrs. Palmer) is Health Projects chairman for the year, and projects range from the young all the way to Community Service for Older Americans, which will get Dorothy Olson's

(Mrs. Leland) attention. Both of these ladies have served on NATIONAL committees in these areas.

My feeling is that if we ALL team up with our husbands to promote good health, we can have quite an impact that will be felt all over the State of Nebraska. This will automatically work for good public opinion for both our husbands, and ourselves. As our immediate past State President, Helen Krause, said, "We must work together as ambassadors for our physician husbands during a time of change in our medical world."

Dr. Harrison L. Rogers, AMA President, pointed out in his inaugural address that doctors will never be replaced. This was certainly brought out to everyone recently when President Reagan had his problems. Who did he call - THE DOCTOR.

Ardis Grace

In Memoriam

By medicine life may be prolong'd
yet death

Will seize the doctor too.

—Shakespeare

Walter W. Carveth, M.D. — (Born August 10, 1895 - died June 26, 1985) — Medical Specialty — General Surgery. Doctor Carveth was a graduate of the University of Nebraska College of Medicine in 1925, and practiced in Lincoln for nearly 50 years. He was a member of the Nebraska Medical Association and the American Medical Association. Doctor Carveth is survived by his wife, Rachel; son, Doctor Stephen W., Lincoln; daughters Joan McKee of Las Vegas, Nev., and Mrs. Bill (Sara) Clay of Grand Rapids, Mich.; sisters, Mrs. Harry (Velvet) Bull and Ruth K. Carveth, both of Lincoln; 13 grandchildren; and four great-grandchildren.

Coming Meetings

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Cocktail Reception — Friday, October 11, 1985, 5:30-7:00 p.m., in conjunction with the American Academy of Family Physicians Meeting, Marriott Hotel, Anaheim, California. All alumni, spouses and friends are invited. Cash bar.

CREIGHTON UNIVERSITY SCHOOL OF MEDICINE ALUMNI DINNER in conjunction with the Omaha Midwest Clinical Society Assembly — Sunday, October 27, 1985, Grand Ballroom, Red Lion Inn, Cash bar - 6:30 p.m.; dinner - 7:30 p.m.; followed by award of 25 and 50-year citations and the Alumni Merit Award which will be bestowed on Robert H. Quinn, M.D. of Sioux Falls, SD. Ticket price is $20 per person and reservations should be sent to Richard L. O'Brien, M.D., Dean, Creighton University School of Medicine, California at 24th Street, Omaha, NE 68178.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION — Alumni Roundup and Reception in Omaha, Monday, October 28, 1985, 6:00-7:30 p.m., Red Lion Inn Ballroom; in conjunction with the Omaha Mid-West Clinical Society Postgraduate Assembly. Cash bar. All alumni, spouses, faculty and friends are cordially invited. Followed at 7:45 p.m. with 50-year dinner in Nebraska Room, Red Lion Inn. Class reunions will be held in Omaha at the end of October for classes ending in "5" and "0".

CREIGHTON UNIVERSITY

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

HEART AND MIND — Oct. 10-12, 1985, Marriott's Tan-Tar-A Resort, Lake of the Ozarks, Osage Beach, Missouri. Program Directors: Emmet M. Kenney, M.D. and Syed M. Mohiuddin, M.D. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

THIRD ANNUAL REVIEW & UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE—February 26-March 5, 1986 at Royal Waikoloa Hotel, Kona, Hawaii. Sponsor: University of Nebraska Medical Center and Creighton University School of Medicine. Credit: 20 Hours AMA Category I. Topics include infectious diseases, adolescent medicine, allergies, rheumatology and pediatric cardiology. Fee: $400 physicians, $250 residents/interns. Contact: Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, Nebraska 68105. Phone: (402) 559-4152 or Hattie DeLapp, Creighton University School of Medicine, Phone: 1-800-228-7212. Ext. 2550.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

MEDICINE AND RELIGION: The Supreme Being, the Supreme Court, and the Almighty Dollar — October 22-23, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Target Audience: Physicians, Nurses, Clergy, Social Workers, Nursing Home Administrators. Contact: Promotion Coordinator, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4488.

ANNUAL INTERNAL MEDICINE SYMPOSIUM — October 9, 10, 11, 1985. Sponsor: University of Kansas Medical Center. Location: Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

53RD ANNUAL POSTGRADUATE ASSEMBLY — Omaha Mid-West Clinical Society, October 28, 29, 30, 1985, The Red Lion Inn, Omaha. For information contact Miss Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 7363 Pacific Street, #205-B, Omaha, Nebraska 68114.

CLINICAL UPDATE I — November 2, 1985. For Southeast Nebraska's M.D.'s and Physicians Assistants. Sponsors: Lincoln Medical Center Association and Lancaster County Medical Society. This is a continuing medical education program designed to address and update the care of patient health care problems presenting in primary care M.D. offices on a day-to-day basis. Approved for 8 credit hours of AMA Category I credit and 8 hours of AAFP credit. Location: Nebraska Center for Continuing Education, Lincoln, Nebraska, 33rd and Holdrege St. Lodging available evenings of November 1 and 2. Reservations will be needed. There is a dinner being planned for the evening of November 2, spouses welcome. Contact: P. D. Duensing, Ed.D., Executive Secretary, Lancaster County Medical Society, (402) 474-2405.

3RD ANNUAL CHRONICALLY ILL AND AGING CONFERENCE — November 21-23, 1985, Oklahoma City, Oklahoma. CME Credits given. For information contact: Dr. John A. Mohr (III), VAMC, 921 NE 13th, Oklahoma City, OK 73104 or call 405-270-5149). (PLEASE NOTE THIS IS THE WEEKEND OF THE OKLAHOMA UNIVERSITY - NEBRASKA GAME AT OKLAHOMA CITY, OKLAHOMA!)

THE NEBRASKA CHAPTER OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS will hold their 38th Annual Scientific Assembly, April 11 and 12, 1986 at the Marriott Hotel, Omaha, Nebraska. Contact: Phyllis Hansen, Executive Director, Nebraska Academy of Family Physicians, 401 No. 117th, Suite 202, Omaha, Nebraska 68154 (402) 333-5856.

The AMA Market Area Profile (MAP) Service

The American Medical Association has announced a new activity that will be of interest to any physician who is interested in developing or modifying a medical practice. The AMA MARKET AREA PROFILE (MAP) SERVICE, created as a part of the Association's Competition Action Plan, is designed to assist physicians in establishing and maintaining a successful medical practice by providing them with detailed demographic and health resource data on an existing or planned practice site.

The MAP Service offers physicians individualized, computer-generated data profiles on any area in the United States. Each Market Area Profile consists of 6 data reports:

*The **Area Profile Report** — 1980 census date (e.g. population, age, sex, housing, occupation, income, etc.) for the area that the physician has selected.

* The **State Area Profile Report** — 1980 census data for the state in which the physician-selected area is located, provided for comparison purposes.

* The **Demographic Trends Report** — 1980, current year, and 5 year projected population and demographic data (e.g. population, age, sex, household size, etc.)

* The **State Demographic Trends Report** — A trends report for the state in which the selected area is located, provided for comparison purposes.

* The **Physician Report** — Statistical information on the number of physicians in the area, by medical specialty, age and major professional activity.

*The **Hospital Report** — Detailed information on hospitals in the selected area, including: number of beds; admissions, utilization and census figures; facilities and services; and a profile of the medical staff. (If there are more than 4 hospitals in the selected area, a summary listing of the hospitals is provided instead.)

The information provided in a MAP profile can be beneficial to all physicians, no matter what their practice situation. New physicians will find it helpful in practice site selection decisions, whether they are investigating specific practice opportunities or comparing several practice sites. Established physicians can use the profiles to make decisions about expanding, relocating or modifying an existing practice. For example, a physician might wish to use the MAP demographic reports to compare his current patient base with the potential patient population of the community. Another physician might want to study the 5 year projected population figures as part of the development of a long range practice plan. In any event, the Market Area Profile Service is a valuable planning tool that can help any physician make the right decisions about a medical practice.

A key feature of the MAP Service is the flexibility offered to the physician subscriber in selecting the area to be profiled. There are four choices: (1) County, (2) Zip Code, (3) City/Town, or (4) Ring Study. The Ring Study option is a unique aspect of the MAP Service that allows the physician to precisely define the area of study in relation to an existing or planned office site. Using a specific street intersection as the center point, the physician can define the area as a ring **of any size** (for example, 5 or 10 miles) around that intersection. This is extremely useful in instances where a standard geographic description does not adequately describe a physician's service area.

The cost of the Market Area Profile Service ranges from $95 to $195, with substantial discounts for AMA members, medical students and residents. Along with the 6 profile reports, physicians receive a User's Manual that provides data source information and offers useful advice on how to interpret and apply the data to a practice situation.

For further information, and to receive the MAP Registration Package, please contact the AMA Market Area Profile Service, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610, (312) 645-4719.

AMA News Notes

Preliminary Check of 12,000 physicians employed by the Veterans Administration indicated that 31 currently have their licenses revoked, suspended, or restricted, according to the AMA Division of Survey and Data Resources. The Dept. of Physician Biographic Records said that the percentage of VA-employed physicians with current licensure problems was relatively low compared with the percentage of physicians with on-going licensure problems in the overall MD and DO population. The VA, which is the nation's largest hospital system, had asked the AMA in June to verify the credentials of its 84,000 affiliated physicians. The AMA's preliminary review of the VA's 7,000 full-time and 5,000 part-time salaried physicians was completed Aug. 9. The credentials of another 23,000 consulting physicians, 43,000 fee-for-service physicians, and 11,000 resident physicians also will be checked against the AMA Physician Masterfile, which is the most comprehensive source of physician information in the United States. The matching process will help determine whether the physicians hold valid degrees, licenses, and specialty board certification. It also will determine whether individual physicians meet the VA's standards for employment. The AMA is conducting similar reviews for the military. The Dept. of Physician Credentials and Qualifications reported that the Association has identified 30 officers with revoked or suspended licenses: eight from the Army, 15 from the Navy, and seven from the Air Force.

* * *

What's in a Name? Most patented drugs have at least three: the chemical name, the 'generic' or non-proprietary name, and the manufacturer's trademark. What do tobramycin, diazepam, and cimetidine have in common? These familiar non-proprietary names all were coined at the AMA's Chicago headquarters in the offices of the United States Adopted Names (USAN) Council. While trade names belong to the manufacturers, non-proprietary names belong to the public. The names are used throughout the medical community and the pharmaceutical industry. Non-proprietary names create a common language for physicians, pharmacists, and patients to identify drugs that may be distributed under a plethora of brand names. The USAN Council's names are accepted by the U.S. Food and Drug Administration, the World Health Organization, and the nomenclature agencies of foreign countries. The AMA has staffed the council since it was founded in 1961. The five-member council, which is co-sponsored by the AMA, American Pharmaceutical Assn., and the U.S. Pharmacopeial Convention Inc., currently approves 125 to 150 new non-proprietary names a year, for a total of 2,335 in its nearly 25-year history.

Many manufacturers market their patented drugs in different countries under different trademarks, and when the patent for a popular drug expires, the number of brand names tends to proliferate. The USAN Council attempts to bring order and logic to the pharmaceutical lexicon, Donald O. Schiffman, Ph.D, director of the AMA Dept. of Medical Terminology and Nomenclature, said in an interview. When manufacturers plan to market a new single-ingredient drug in the United States, they submit possible names for the council's approval. From the manufacturers' point of view, non-proprietary names have the advantage of protecting the trademarks they use to promote brand recognition for their products. The USAN staff rules out look-alike names, spelled-alike names, or new names for previously listed compounds. The council's rule of thumb is to coin names that are unique, short, and simple. Originally, the non-proprietary names were shorthand versions of long, cumbersome, and usually unpronounceable chemical names. Today, while the non-proprietary name may echo some syllables of the chemical name, the council adds prefixes and suffixes to show the drug's chemical and therapeutic kinship to other drugs. Once the council christens a drug, it publishes the new name and information on the compound in the **Journal of Clinical Pharmacology and Therapeutics.** Reprints may be obtained by writing to the Dept. of Medical Terminology, AMA headquarters, Chicago. Copies of the 628-page 1986 edition of the **USAN and the**

(Continued on page 17A)

3efore prescribing, see complete prescribing information in SK&F CO.
iterature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents
uch as spironolactone or amiloride. Further use in anuria, progressive
enal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
otassium. Hypersensitivity to either component or other sulfonamide-
erived drugs.

Varnings: **Do not use potassium supplements, dietary or otherwise, unless
ypokalemia develops or dietary intake of potassium is markedly impaired.**
supplementary potassium is needed, potassium tablets should not be
sed. Hyperkalemia can occur, and has been associated with cardiac irregu-
arities. It is more likely in the severely ill, with urine volume less than
ne liter/day, the elderly and diabetics with suspected or confirmed renal
nsufficiency. Periodically, serum K^+ levels should be determined. If hyper-
alemia develops, substitute a thiazide alone, restrict K^+ intake. **Asso-
lated widened QRS complex or arrhythmia requires prompt additional
herapy.** Thiazides cross the placental barrier and appear in cord blood.
Jse in pregnancy requires weighing anticipated benefits against possible
azards, including fetal or neonatal jaundice, thrombocytopenia, other
dverse reactions seen in adults. Thiazides appear and triamterene may
ppear in breast milk. If their use is essential, the patient should stop
ursing. Adequate information on use in children is not available. Sensitivity
eactions may occur in patients with or without a history of allergy or
ronchial asthma. Possible exacerbation or activation of systemic lupus
rythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of
Dyazide' is about 50% of the bioavailability of the single entity. Theoreti-
ally, a patient transferred from the single entities of Dyrenium (triamterene,
SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure
r fluid retention. Similarly, it is also possible that the lesser hydro-
hlorothiazide bioavailability could lead to increased serum potassium levels.
lowever, extensive clinical experience with 'Dyazide' suggests that these
onditions have not been commonly observed in clinical practice. Do
eriodic serum electrolyte determinations (particularly important in patients
omiting excessively or receiving parenteral fluids, and during concurrent
se with amphotericin B or corticosteroids or corticotropin [ACTH]).
eriodic BUN and serum creatinine determinations should be made,
specially in the elderly, diabetics or those with suspected or confirmed
enal insufficiency. Cumulative effects of the drug may develop in patients
vith impaired renal function. Thiazides should be used with caution in
atients with impaired hepatic function. They can precipitate coma in
atients with severe liver disease. Observe regularly for possible blood
yscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias
ave been reported in patients receiving triamterene, and leukopenia,
hrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia
ave been reported with thiazides. Thiazides may cause manifestation of
atent diabetes mellitus. The effects of oral anticoagulants may be
ecreased when used concurrently with hydrochlorothiazide; dosage adjust-
nents may be necessary. Clinically insignificant reductions in arterial
esponsiveness to norepinephrine have been reported. Thiazides have also
een shown to increase the paralyzing effect of nondepolarizing muscle
elaxants such as tubocurarine. Triamterene is a weak folic acid antagonist.
o periodic blood studies in cirrhotics with splenomegaly. Antihypertensive
ffects may be enhanced in post-sympathectomy patients. Use cautiously
surgical patients. Triamterene has been found in renal stones in asso-
iation with the other usual calculus components. Therefore, 'Dyazide'
hould be used with caution in patients with histories of stone formation.
few occurrences of acute renal failure have been reported in patients on
Dyazide' when treated with indomethacin. Therefore, caution is advised in
dministering nonsteroidal anti-inflammatory agents with 'Dyazide'. The
ollowing may occur: transient elevated BUN or creatinine or both, hyper-
lycemia and glycosuria (diabetic insulin requirements may be altered),
yperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing
lkali reserve with possible metabolic acidosis. 'Dyazide' interferes with
uorescent measurement of quinidine. Hypokalemia is uncommon with
Dyazide', but should it develop, corrective measures should be taken such
s potassium supplementation or increased dietary intake of potassium-
ch foods. Corrective measures should be instituted cautiously and serum
otassium levels determined. Discontinue corrective measures and
Dyazide' should laboratory values reveal elevated serum potassium.
hloride deficit may occur as well as dilutional hyponatremia. Concurrent
se with chlorpropamide may increase the risk of severe hyponatremia.
Serum PBI levels may decrease without signs of thyroid disturbance. Cal-
ium excretion is decreased by thiazides. 'Dyazide' should be withdrawn
efore conducting tests for parathyroid function.

hiazides may add to or potentiate the action of other antihypertensive
rugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium
oxicity.

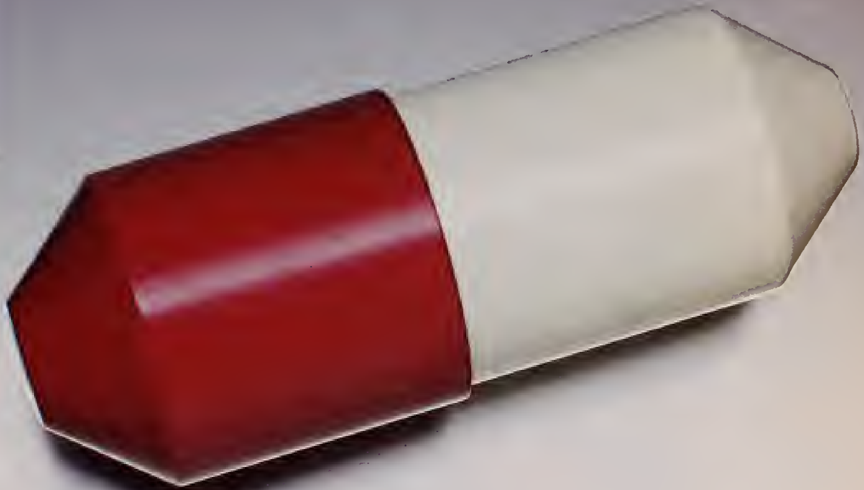
dverse Reactions: Muscle cramps, weakness, dizziness, headache, dry
nouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermat-
logical conditions; nausea and vomiting, diarrhea, constipation, other
astrointestinal disturbances; postural hypotension (may be aggravated by
lcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias,
cterus, pancreatitis, xanthopsia and respiratory distress including pneu-
nonitis and pulmonary edema, transient blurred vision, sialadenitis, and
ertigo have occurred with thiazides alone. Triamterene has been found in
enal stones in association with other usual calculus components. Rare
ncidents of acute interstitial nephritis have been reported. Impotence has
een reported in a few patients on 'Dyazide', although a causal relationship
as not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of
000 capsules; Single Unit Packages (unit-dose) of 100 (intended for
nstitutional use only); in Patient-Pak™ unit-of-use bottles of 100.**
RS-DZ:L39

In Hypertension*...
When You Need to
Conserve K+

Remember the Unique
Red and White Capsule:
Your Assurance of
SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



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Over 19 Years of Confidence

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Your assurance of
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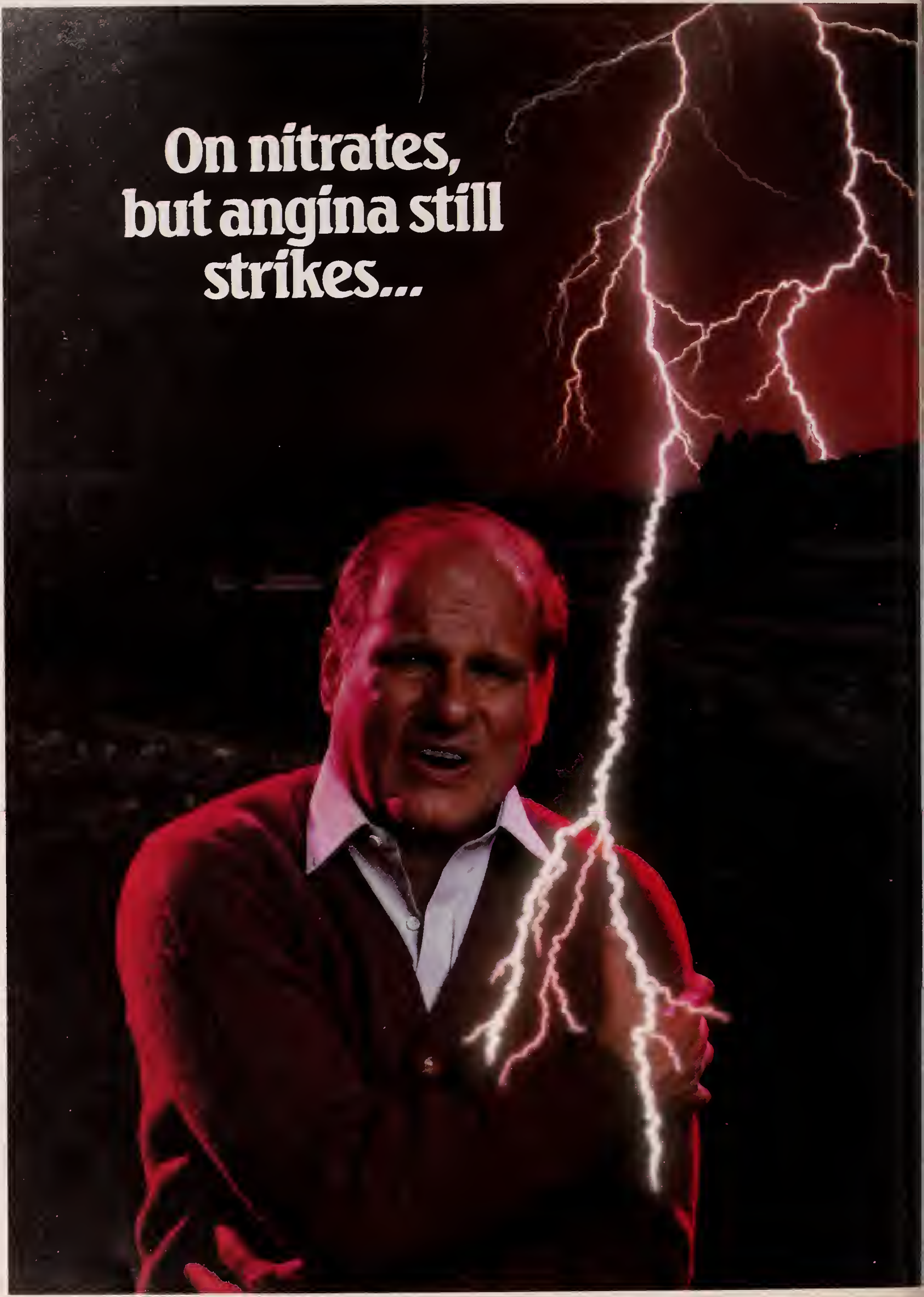
On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions*.) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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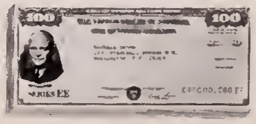

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AMA News Notes

(Continued from page 388)

USP Dictionary of Drug Names are now available from the U.S. Pharmacopeial Convention Inc., 12601 Twinbrook Parkway, Rockville, Md. 20852. The price for a single copy is $54.95.

* * *

Assn. of Trial Lawyers of America was taken to task for its public position on the professional liability crisis. ATLA has disputed the AMA's charges that problems in the U.S. legal system are in large part responsible for the crisis. ATLA represents many plaintiffs' lawyers who bring medical malpractice lawsuits. In a 26-page, point-by-point factual rebuttal, the AMA Task Force on Professional Liability and Insurance, refuted a 12-page position paper by Thomas G. Goddard, ATLA Public Affairs Dept. The paper, which has been widely circulated as ATLA's definitive response to the AMA, denied that a medical 'malpractice' crisis exists. ATLA blamed the insurance industry and physicians themselves for the increase in claims and awards. 'ATLA's self-serving attacks on the medical profession do not advance the discussion of the problem,' the AMA rebuttal concluded. 'Physicians, and the patients they serve, are plainly suffering today because of the professional liability situation.'

* * *

Professional liability premiums have increased by 44.8% in the last two years, the AMA Task Force on Professional Liability and Insurance said in its response to the Assn. of Trial Lawyers of America. Even in low-risk specialties, premium increases have been dramatic. General practitioners and physicians practicing internal medicine have experienced premium increases of 31.4% and 32.4%, respectively, since 1982. Citing the latest information from the AMA Center for Health Policy Research, the task force said that premium costs for many highly specialized physicians now approach one-third of their gross incomes, driving some physicians out of practice and causing others to provide fewer high-risk services. The level of premiums varies greatly particularly across specialties and locations. Premiums are substantially higher for surgical specialties and obstetrics/gynecology. In 1984, the average obstetrician/gynecologist paid $18,800 — more than 16% of before-tax net income — on insurance premiums alone. In some states, the premiums are much higher. For all physicians across the country, 1984 premiums averaged $8,400 or almost 8% of before-tax net income.

* * *

State-By-State Annotation of the legal status of the hospital medical staff has been prepared by the AMA Office of the General Counsel. The 38-page document has been mandated by the House of Delegates. Resolution 153 (A-85) called for preparation of the document 'as quickly as possible.' The resolution also directed the AMA to distribute the document to each component society and to each registrant at the most recent meeting of the AMA Hospital Medical Staff Section within 60 working days of the close of the Annual Meeting. The status of the organized medical staff as legally separate from the hospital governing body is a matter that has been determined by custom and usage, long-standing traditional relations, accreditation standards of the Joint Commission on Accreditation of Hospitals, and legislation and judicial precedents, according to the OGC report. This separate status is relevant when the medical staff represents the interests of staff members or patients in disputes with the hospital. Copies of the report were mailed Aug. 29 to AMA delegates, alternate delegates, state medical associations, national specialty societies, and HMSS attendees. Additional copies are available from the Office of the General Counsel, AMA headquarters, Chicago. The telephone number is (312) 645-4601.

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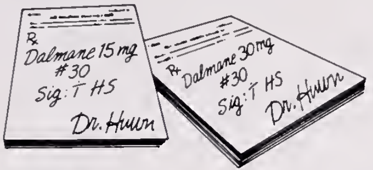

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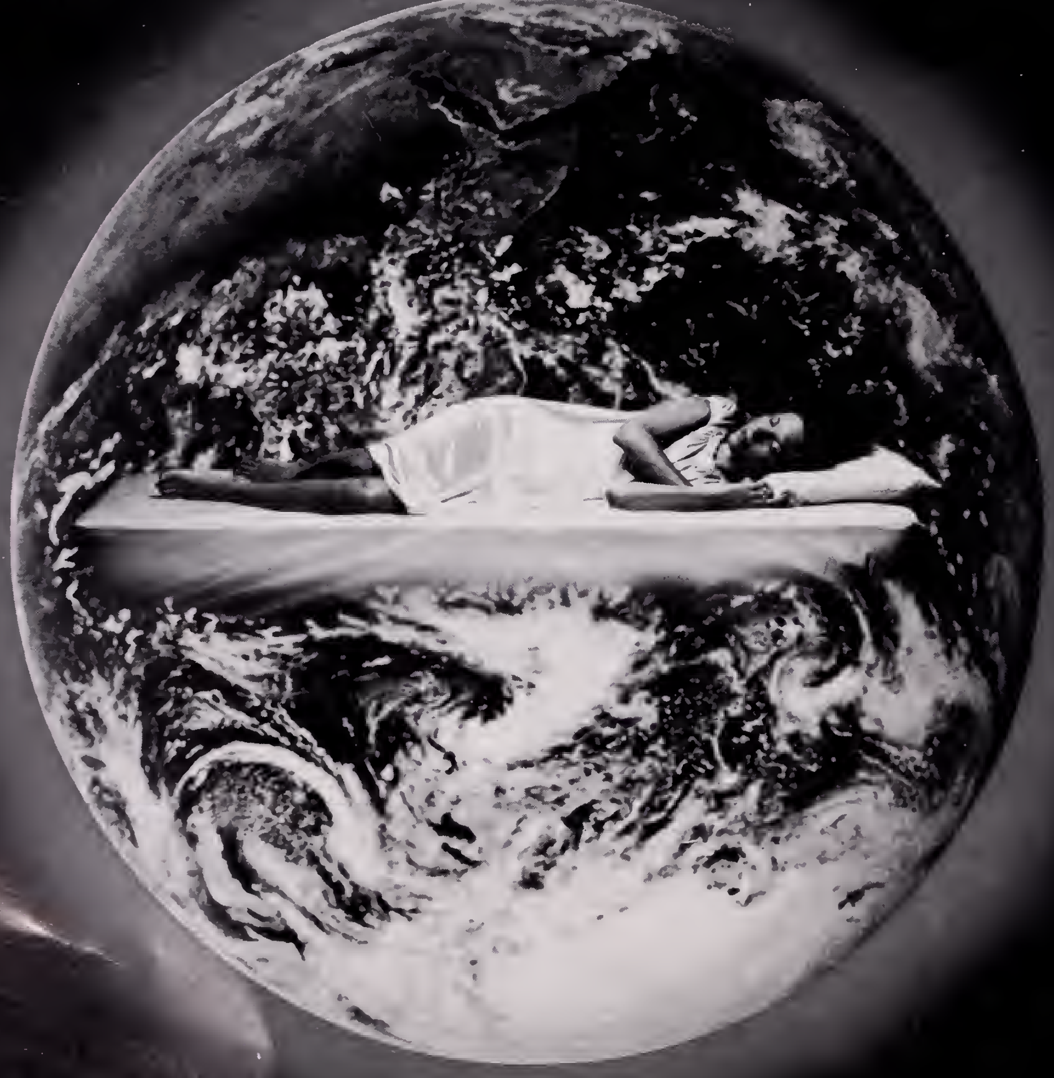

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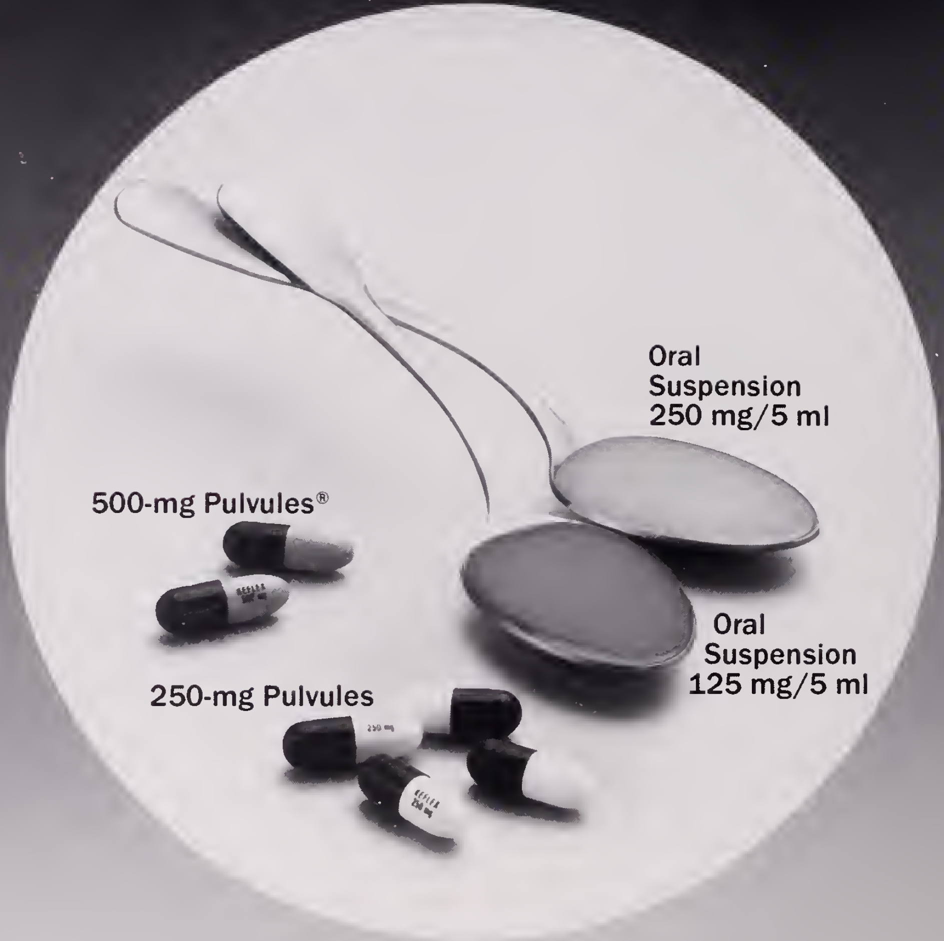

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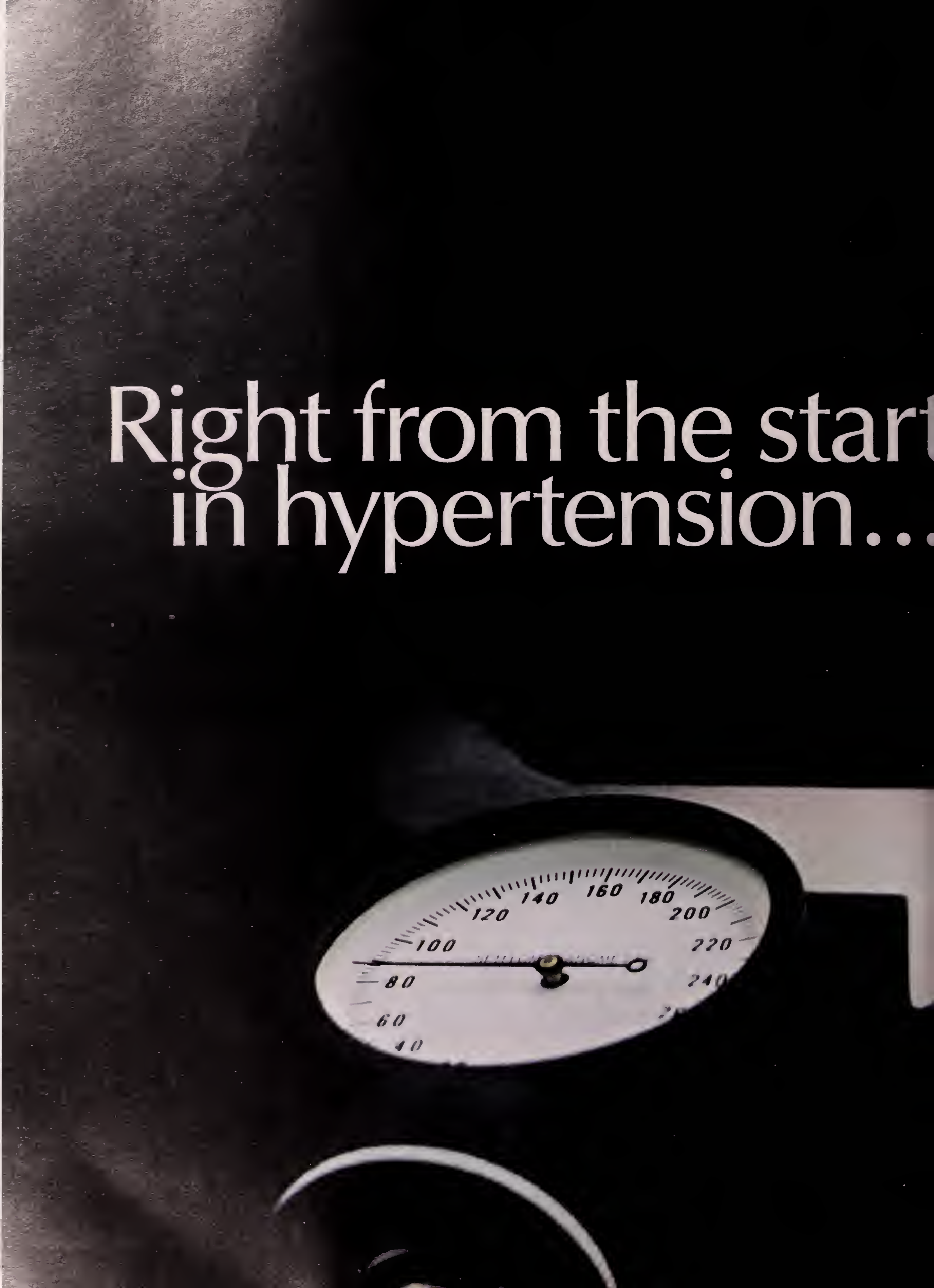
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80 mg 120 mg 160 mg

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Please see brief summary of prescribing information on the next page for further details.

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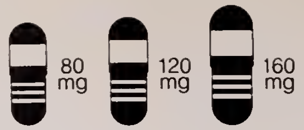

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of bet receptor agonists and its effects can be reversed by administration of such agents, e g dobutamine or isoproterenol However, such patients may be subject to protracted seve hypotension. Difficulty in starting and maintaining the heartbeat has also been reported wi beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the ap pearance of certain premonitory signs and symptoms (pulse rate and pressure changes) acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be mo difficult to adjust the dosage of insulin

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidis Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympto of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function test

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have bee reported in which, after propranolol, the tachycardia was replaced by a severe bradycard requiring a demand pacemaker In one case this resulted after an initial dose of 5 m propranolol

PRECAUTIONS. *General*. Propranolol should be used with caution in patients with impaire hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patien should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal m lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart diseas elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as rese pine should be closely observed if INDERAL is administered The added catecholamin blocking action may produce an excessive reduction of resting sympathetic nervous activ which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthosta hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals ha been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significa drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosa levels Reproductive studies in animals did not show any impairment of fertility that w attributable to the drug

Pregnancy Pregnancy Category C. INDERAL has been shown to be embryotoxic animal studies at doses about 10 times greater than the maximum recommended human dos

There are no adequate and well-controlled studies in pregnant women. INDERAL shou be used during pregnancy only if the potential benefit justifies the potential risk to the fetu

Nursing Mothers. INDERAL is excreted in human milk Caution should be exercised wh INDERAL is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and ha rarely required the withdrawal of therapy.

Cardiovascular bradycardia, congestive heart failure; intensification of AV block, hyp tension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of t Raynaud type.

Central Nervous System lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visu disturbances, hallucinations, an acute reversible syndrome characterized by disorientation time and place, short-term memory loss, emotional lability, slightly clouded sensorium, a decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhe constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achi and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytope purpura

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has be reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reacti involving the skin, serous membranes and conjunctivae reported for a beta blocker (practo have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride i sustained-release capsule for administration once daily If patients are switched from INDER tablets to INDERAL LA capsules, care should be taken to assure that the desired therape effect is maintained INDERAL LA should not be considered a simple mg for mg substitute INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration m be necessary especially to maintain effectiveness at the end of the 24-hour dosing interv

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic The dosage may increased to 120 mg once daily or higher until adequate blood pressure control is achiev The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 6 mg may be required The time needed for full hypertensive response to a given dosage variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily In angina pectoris, the value a safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few wee (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL once daily The usual effective dose range is 160-240 mg once daily The dosage may increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA thera should be discontinued It may be advisable to withdraw the drug gradually over a perio several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use

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1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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(ISOSORBIDE DINITRATE)

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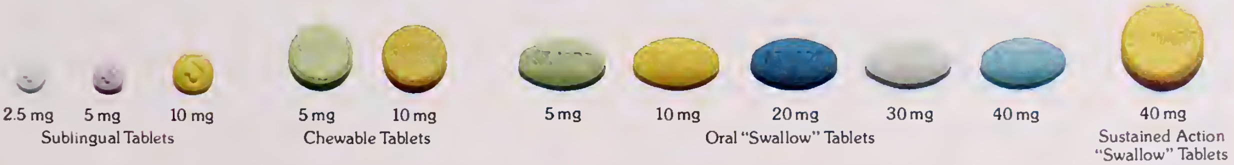

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See following page for brief summary of prescribing information.

SORBITRATE™
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg, for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg), Sustained Action Tablets (40 mg)

STUART PHARMACEUTICALS
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Wilmington, DE 19897

AMA News Notes

Growing Backlog of Medicare Part B Claims has been the subject of a series of meetings that the AMA and national medical specialty societies have held with the Health Care Financing Administration. According to HCFA officials, a major reason for the backlog is that the volume of claims began to increase at about the same time that federal allocations for processing them was cut. Last January, the average turnaround time for Part B claims was seven work days. By August, the average turnaround time had stretched to 12 days. HCFA's Bureau of Program Operations estimated that the average turnaround time would be 15 days by December. Last May, the AMA called for meetings with the national specialty societies and HCFA to address the mounting number of complaints from physicians about claims payments and service. Most complaints were attributable to requirements that all carriers must convert their procedure codes to **Current Procedural Terminology,** fourth edition (CPT-4) and implement prepayment screens to identify potential overutilizers. The conversion from existing procedure codes to CPT-4 was scheduled to be completed this month. The AMA and national medical specialty societies met with HCFA officials in June, July, and August.

* * *

PRO Monitoring Project has received more than 100 letters from physicians in 26 states in response to the AMA's request for information, the Association's Dept. of Health Care Financing and Organization reported. In the letters, the physicians described their experiences with local peer review organizations. About half of the letters came from physicians writing as individuals. The rest were from hospital medical staff chiefs, physicians in group practices, and MD chairmen of hospital review committees. The physicians mentioned the PROs' conflicting and sometimes confusing directives. They also objected to reviews of their cases by other physicians outside their specialties. Telephone interviews with 45 state medical societies and three metropolitan county societies indicated that

(Continued on page 17A)

THE NEBRASKA MEDICAL JOURNAL

Our Journal

EDWARD A. HOLYOKE, JR., M.D.

I like to keep periodicals and publications. My wife will be upset when she reads this because I have thrown out countless magazines she wanted to keep. If I didn't do this, there wouldn't be room for mine. But now and then I go through my file, keep what is worth keeping, and throw the rest away, not without some sadness. I was working at this task the other day and found that I have saved almost every issue of The Nebraska State Medical Journal since I began receiving it 15 years ago. I started to read through some of these older issues and accomplished very little else. My file is still full.

There have been many fine articles published in our Journal. Major breakthroughs in medical research have appeared in some of these publications. Literature reviews, case reports, and pieces of historical interest have also been included.

Our former editor, Dr. Frank Cole, really had a way with words. We didn't have an editorial board then, so Dr. Cole wrote all the editorials himself, reviewed all the manuscripts himself, and generally took responsibility for the entire publication.

He often included a little section which he called, "Words I Can Do Without." A few choice examples: vitaminiferous, incremental, in lieu of, unbeknownst. I think I'll add some in a list I would label, "Words I Can't Tolerate Anymore." Here are a few: criterion, deny, preadmission, outlier (I don't even know what this means).

I remember one editorial in particular that Dr. Cole wrote. It was entitled, "Who Reads Progress Notes?" and its text follows:

"I"[1]

We can be proud of our Journal. Dr. Forker and his staff have done an outstanding job. The Journal brings us good news, such as the recent election of Dr. Jerald Schenken to the AMA Board of Trustees. It brings us notes of sadness in the passing of our colleagues. It keeps us informed of coming meetings and of the activities of the Nebraska Medical Association, its Commissions and the House of Delegates. And I can't begin to emphasize how important this information is for all of us. We need material from all areas and specialties of medicine. So, keep those manuscripts and letters coming!

Several years ago our Journal was awarded the national championship in competition with state medical journals; we were number one. I think we still have the best state journal. And I am proud to be a part of it.

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1. Cole F: Who reads progress notes? Nebr State Med J 64:245, 1979.

Revised American Heart Association Recommendations for SBE Prophylaxis

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HEALTH professionals have been made aware of the importance for subacute bacterial endocarditis (SBE) prophylaxis for patients with rheumatic or congenital heart disease. Recently, the Committee on Rheumatic Fever and Infective Endocarditis of the Council on Cardiovascular Disease in the Young has updated its recommendations for SBE prophylaxis.[1] The purpose of this editorial is to highlight areas where the changes have occurred.

One of the new recommendations from the Committee is the antibiotic dosage regimen. The new dosages and time intervals are listed in Table 1. The major change is in the post-procedure dosage. Whereas the old recommendation included giving antibiotics for as long as two days after the procedure, now only one dose at the most is necessary.

Several other recommendations have been changed. Unless associated with a procedure for which prophylaxis is recommended, endotracheal intubation alone does not require prophylactic antibiotics. Also, antibiotics are not needed for brief bladder catheterization in a patient who has sterile urine.

The Committee also now recommends offering only oral and not parenteral prophylaxis to patients with artificial valves who maintain a high level of oral health for routine dental procedures, such as filling cavities. However, the regular parenteral Type B regimen is recommended for dental extractions, oral or gingival surgical procedures.

Patients undergoing open-heart surgery should be started on prophylaxis immediately before the operative procedure but continued for no more than two days postoperatively. This short treatment is an attempt to minimize the emergence of resistant organisms postoperatively.

The recommendations regarding administration of antibiotics in patients who are anticoagulated have been refined. It is the Committee's recommendation that in patients receiving heparin, antibiotic prophylaxis should be administered intravenously or orally because intramuscular injections are contraindicated in these patients. Patients receiving warfarin sodium (Coumadin®) are recommended to have antibiotic prophylaxis via intravenous or oral routes; however, intramuscular injections can be given if necessary.

Antibiotic coverage continues to be recommended once just before a procedure, **not** several doses for days before. Appropriate antibiotic prophylaxis for SBE should be prescribed for patients with rheumatic fever, because antibiotic prophylaxis used to prevent rheumatic heart disease fails to provide adequate coverage against SBE.[2]

Continued emphasis remains for SBE coverage for **all** dental procedures, including routine professional cleaning that is likely to induce gingival bleeding. However, spontaneous shedding of deciduous teeth and simple adjustment of orthodontic appliances does not require prophylaxis.

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TABLE I. SBE PROPHYLAXIS

	Congenital Heart Disease or Acquired Valvular Disease (Type A)	Artificial Valve Replacements (Type B)
Procedure	**Drug Dosage**	**Drug Dosage**
ALL DENTAL PROCEDURES (INCLUDING PROFESSIONAL CLEANING) AND UPPER RESPIRATORY TRACT SURGICAL PROCEDURES		
Oral Treatment:	Penicillin V: Over 60 lbs - 2.0 g. p.o. 1 hr. before procedure, then 1.0 g. p.o. 6 hrs. after procedure (1 dose only) Under 60 lbs - 1.0 g. p.o. 1 hr. before procedure, then 500 mg p.o. 6 hrs. after procedure (1 dose only)	
Parenteral Treatment:	Aqueous Penicillin 50,000 u/kg (2 million units max.) IV or IM 30 min.-1 hr. before procedure, then 1 dose 6 hrs. after procedure (may use Aqueous Penicillin G, 25000 u/kg (1 million units max.) for this dosage or Penicillin V as in Oral Treatment.	Ampicillin 50 mg/kg (2.0 g. max.) and Getamicin 2.0 mg/kg (80 mg max.) IM or IV 30 min.-1 hr. before procedure, then Penicillin 1.0 g. p.o. 6 hrs. after procedure. Alternatively, parenteral B regimen should be repeated 8 hrs. after procedure (1 dose only)
Penicillin Allergic Patients:	Erythromycin 20 mg/kg (1 g. max.) p.o. 1 hr. before procedure, then 10 mg/kg (500 mg max.) p.o. 6 hrs. after procedure (1 dose only)	Vancomycin 20 mg/kg (1.0 g. max) IV slowly 1 hr. before procedure. No repeat dose is necessary.
GENITOURINARY/ GASTROINTESTINAL	Ampicillin 50 mg/kg (2.0 g. max.) IM or IV and Gentamicin 2.0 mg/kg (80 mg max.) IM or IV 30 min. before procedure, then repeat 8 hrs. after procedure (1 dose only)	Ampicillin 50 mg/kg (2.0 g. max) IM or IV and Gentamicin 2.0 mg/kg (80 mg max.) IM or IV 30 minutes before procedure, then repeat 8 hrs. after procedure (1 dose only)
Penicillin Allergic Patients:	Gentamicin 2.0 mg/kg (80 mg max.) IM or IV and Vancomycin 20 mg/kg (1.0 g. max.) IV slowly 1 hr. before procedure, then repeat 8-12 hrs. after procedure (1 dose only)	Gentamicin 2.0 mg/kg (80 mg max.) IM or IV and *Vancomycin 20 mg/kg (1.0 g. max.) IV slowly 1 hr. before procedure, then repeat 8-12 hrs. after procedure (1 dose only)
MINOR OR REPETITIVE PROCEDURES IN LOW RISK PATIENTS	Amoxicillin 50 mg/kg (3.0 g. max) p.o. 1 hr. before procedure, then 25 mg/kg (1.5 g. max.) p.o. 6 hrs. after procedure (1 dose only)	Amoxicillin 50 mg/kg (3.0 g. max.) p.o. 1 hr. before procedure, then 25 mg/kg (1.5 g. max.) p.o. 6 hrs. after procedure (1 dose only)

Although these revisions of the American Heart Association guidelines certainly are welcome, a word of caution is emphasized. It is stated several times in the new report that physician discretion remains an important factor in determining whether or not an individual patient requires SBE prophylaxis. The American Heart Association report lists several procedures that have never been associated with documented endocarditis (e.g. tympanoplasty, barium enema, vaginal delivery, minor gynecological procedures). Therefore, the Committee does not recommend routine SBE prophylaxis for these procedures; however, they warn "it would be prudent to administer prophylactic antibiotics for these low-risk procedures" in patients who are known to have a high risk for endocarditis (e.g. those with prosthetic heart valves or sytemic artery to pulmonary artery shunts). Thus, to emphasize this point, we conclude by recommending continued physician discretion while following the new American Heart Association recommendations.

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Capgras Syndrome in Court

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IN 1923 Capgras & Reboul-Lachaux presented a case of a woman suffering from paranoid psychosis who asserted that her husband and children had been replaced by doubles. They called this condition as L'Illusion Des "Sosies,"[1] but afterwards it was given the title of Capgras Syndrome by Levy-Valensin. The central feature of Capgras Syndrome is the patient's belief that the body of an acquaintance is taken over by an identical imposter or double. It is the delusional negation of the identity of familiar persons.[2] Until 1936 this syndrome was believed to be found exclusively in females, but many male patients have since been reported. Paranoid schizophrenia is a common diagnosis, but many cases with other disorders have also been discussed. Treatment is usually directed at the underlying disorder. With successful treatment of underlying disorders the syndrome usually clears, but not all the time.[3] Precipitation of similar disorder is generally accompanied by same delusions involving doubles.

The purpose of the present paper is to report a patient in which the emergence of Capgras Syndrome was accompanied by an act of violence which resulted in the shooting and killing of his sister. This patient is also interesting because his schizophrenic illness, manifesting primarily in the form of Capgras Syndrome, was successfully used to prove the patient's insanity at the time of the commision of the act.

Case Report:

A 29 year old caucasian male was admitted in July 1980 to the security unit following a police hold. Reportedly the patient shot and killed his sister which prompted his arrest and subsequent placement in our facility.

More than 8 months prior to this criminal act, the patient started presuming himself as a leader, gifted with special values and powers. He also felt that people were jealous of his achievements, and acting against him. Because of his superior position, he believed people were watching and monitoring him very closely. This change in his behavior was thought to be the result of stress accompanying his divorce which occurred immediately prior to manifestation of symptoms. As his mental state deteriorated further, he started perceiving that many of the people around him had been replaced by imposters who he felt were actors somehow associated with the Mafia. He also felt that his parents and siblings had been replaced by imposters. The delusional belief of impostery even extended to people whom the patient knew only from a distance.

As his delusional belief became more pervasive, the patient felt scared and thought that imposters who were monitoring him wanted to kill him. One day he barricaded himself in the basement of his house in an effort to escape from the attention of imposters surrounding him. He also kept a loaded gun to use if somebody approached him.

As the patient's sister tried to approach him in an apparent attempt to help, he panicked. He fired a shot as a warning signal into the porch which hit his sister and killed her. The patient believed that the woman thus killed was not his sister but was one of the many imposters surrounding him.

Upon admission, his physical examination revealed congenital bicuspid aortic valve malfunction. Neurological examination revealed no gross evidence of neurological dysfunction. Lab investigation, which included UA, CBC with differential, liver function tests, serum electrolytes, blood glucose and other enzyme studies were in the normal range. His psychological testing revealed that the patient was suffering from schizophrenic illness. Testing with the Luria-Nebraska battery revealed no organic brain dysfunctions. Previous life history revealed a well adjusted married man. There was no history of head trauma.

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He was diagnosed as suffering from Paranoid Schizophrenia and was started on antipsychotics in appropriate doses. While in the security unit, the patient felt that most of the staff members and even his doctors were imposters who were continuously monitoring his actions. With the help of pharmacotherapy and milieu therapy, his condition improved and he was declared as competent to stand trial. However, legal proceedings against him were dropped as he was thought to be insane at the time of the commission of the act because of his delusional thinking involving Capgras Syndrome.

After staying in the security unit for more than 2 years, the patient's mental condition improved considerably. He was discharged to outpatient treatment where he maintained his improvement. But he continued to maintain the same delusion regarding the shooting of his sister. Again after one year, the patient suffered from exacerbation of paranoid schizophrenia with re-emergence of the same delusions of doubles. This necessitated his readmission to our acute care facility where again with adequate doses of antipsychotic treatment, his schizophrenic symptomatology was brought under control.

Discussion

It has been thought in the past that only those love objects, whether inanimate or animate, to whom the patient is tied with intense affective sentiments are involved in doubling.[4] But in the case of our patient, the Capgras delusions were so pervasive that even the people the patient knew only from a distance were also involved in doubling.

It is thought that development of Capgras delusion is used by the patient as a primitive defense mechanism to facilitate expression of unconscious hostility and rage towards a love object without the experience of any guilt feelings.[5] However, in our patient rage and hostility directed towards the imposters was so intense that it resulted in the shooting and killing of his sister. With psychiatric intervention the patient's mental state improved significantly and, accordingly, his Capgras delusions started fading away. He continued to maintain the delusion of killing the imposter but not his sister. It seemed to be too painful for him to accept the reality that he killed his sister.

In many of the most recent reports, organic brain illness has been implicated in the causation of Capgras Syndrome,[6] but in our patient there are no identifiable organic brain lesions which can be considered as causative factors. It must be emphasized, however, that presentation of Capgras Syndrome with or without other delusions should warrant a comprehensive examination for organic brain dysfunctions.

Review of the literature published on Capgras Syndrome revealed only one male patient who exhibited violence associated with Capgras delusions, in the form of seriously injuring his mother with a meat cleaver.[7] In another report, a male patient showed only the desire to become violent towards the supposed imposters.[8] In our patient, the emergence of Capgras delusions resulted in an extreme degree of violence directed towards the supposed imposters which ultimately led on to the shooting and killing of his sister. Later on, when the patient was brought to trial, schizophrenic illness manifesting primarily in the form of Capgras Syndrome was used for insanity defense. The court agreed that as a result of his mental illness with its major distortion of reality and Capgras delusions, he lacked substantial capacity at the time of the commission of the crime. Thus, he was declared Not Responsible by Reason of Insanity and was acquitted of any crime.

From this discussion we may conclude that patients experiencing Capgras delusions can become dangerously violent and all such patients should be evaluated thoroughly for any criminal intent or dangerousness. Personal safety should be ensured before approaching such patients.

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The Otolaryngic Evaluation and Management of the Dizzy Patient

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THE dizzy patient is always a challenge and commonly a diagnostic puzzle to the practicing physician. Therefore, it is extremely advantageous to have a logical, concise protocol in which to approach the diagnosis and treatment of dizziness and vertigo.

Dizziness is defined as any disturbed relationship to space. The body is oriented in space by the complicated integration of information supplied to the central nervous system by the eyes, eye muscles, cerebellum, vestibulospinal tract, propioceptive system, medial longitudinal fasciculus (MLF), and the statokinetic system or inner ear and vestibular nuclei.[1] Of these systems, three primarily control equilibrium: the eyes, statokinetic system and the propioceptive system.[1] If there is a defect in only one of these systems, the patient will experience dysequilibrium. However, if two or more systems are affected, the patient can be totally incapacitated.

It is necessary to understand that vertigo and dizziness are related but different subjects. Dizziness is described as a light-headed "giddy" imbalance causing a disturbed orientation in space. Vertigo implies a sensation of whirling, falling or a tilting motion. True vertigo is caused by a specific lesion of the statokinetic system, which includes the semicircular canals, utricle, vestibular nerve, and vestibular nuclei.

History

An accurate and complete history is important in the evaluation of the dizzy patient. The following history along with a complete review of systems should be obtained.

Patients will often have difficulty in describing the type of motion or dizziness experienced. The sensation is often described as whirling, a feeling of propulsion or falling. The direction of motion is not important, but the fact that the patient describes a sensation of movement is.[1,2] This points to the statokinetic system as a probable etiologic site and implies true vertigo. If the history does not elicit a reported sensation of motion, the differential must be expanded to include a multisystem evaluation not limited to the statokinetic workup.[3]

In true vertigo, localization of the disease may manifest itself as a progressive unilateral hearing loss; however, it should be remembered that true vertigo can also occur without associated hearing loss.[1,3] Tinnitus is another common complaint. This is usually described as a constant nonpulsatile chirping, humming or buzzing in the ear. If the tinnitus is described as pulsatile, it is possibly the patients' perception of his own heartbeat,[3] but a vascular tumor must be excluded.

It is important to ascertain the nature of the symptoms as well as time related factors and recent medical history. (i.e. recent infection, medications, trauma, etc.) A definite pattern of the dizziness, i.e. whether it is continuous, occurs paroxysmally or is simulated by positioning of the patient, will add significantly to the patient's evaluation.[1,3]

If the dizziness is severe, the patient may complain of nausea, vomiting and have objective nystagmus. A severe degree of dizziness often implies an endorgan problem, while mild dizziness may arise from disease anywhere in the body and necessitate an extensive multisystem work-up.[1]

Physical Examination

While the physical exam for the dizzy patient is often normal, it is important to be aware of certain signs that may help determine the etiology of the dizziness.

Spontaneous nystagmus is the single most important physical sign in the dizziness evaluation. When checking for nystagmus, have the patient look straight ahead in a neutral position since the nystagmus evoked by having the patient gaze to the side is often a normal variant, whereas spontaneous nystagmus with eyes directed forward has great significance.[1,3] If it is a horizontal nystagmus, it indicates probable peripheral vestibular disease. Vertical nystagmus is diagnostic of a central nervous system lesion[1,3] and a neurologic consultation should be obtained. A "fine" nystagmus, not perceptable to the naked eye, may also be present if the ocular muscles are compensating the eye jerks. A fundoscopic exam will often detect these fine movements. In addition, Frenzel, (+20) lenses will not allow the patient to focus on surrounding objects to stabilize the nystagmus and therefore allow the nystagmus to be detected.[1,3]

An eye examination is necessary since it may be a contributing factor or the entire cause of dizziness. Diplopia or eye muscle imbalance may be the cause of the dizziness and can be corrected by surgery or physical therapy. Glaucoma is a potential etiology and can be evaluated by a routine glaucoma check. Corneal reflexes should be examined to help rule out a possible cerebellar pontine angle tumor.[1]

A complete otologic examination can reveal some of the simplest causes for dizziness. Excess cerumen build-up or external canal foreign objects can cause a mild vertigo. A retracted tympanic membrane, cholesteatoma, trauma, chronic otitis media, or a fistula of the labyrinth are other possible etiologies.[1,3] A pure tone audiogram should be done in all patients complaining of dizziness, even if no subjective hearing loss is present. A high frequency hearing loss is often discovered with the dizzy patient and the audiogram may help to localize the problem.[1] The pure tone audiogram can also lead to the diagnosis of a specific problem such as Meniere's disease since certain audiometric patterns are associated with specific disease of the ear.

Brain Stem Evoked Response (BSER) audiometry records brain stem activity induced by a click stimulus; it is recorded via scalp electrodes then averaged by a computer. The electrical potentials give a fairly accurate estimate of the function of the eighth nerve, auditory tracts and nuclei within the brain stem. The BSER will help differentiate retrocochlear from cochlear lesions. Small lesions may selectively effect portions of the auditory/vestibular system; therefore, the patient may have normal hearing with concurrent vertigo with the lesion affecting only the vestibular portion.[1]

The caloric tests, whether done alone or in conjunction with a formal ENG, can further help identify the location of a lesion. Nystagmus is named for the quick component of the eye movement elicited by ice water stimulus or diseased labyrinth. The normal response, when irrigating with cold water, is to evoke a nystagmus toward the opposite side, and when warm water is used the nystagmus is towards the same side as the stimulus, i.e. COWS = Cold Opposite Warm Same. A hyperactive response may indicate irritation to the endorgan system by certain stimuli, i.e., medications, endocrine abnormalities or motion sickness.[1, 3] A hypoactive responseis indicative of a disease process in the labyrinth.[1] (Figure 1)

Electronystagmography (ENG) is an objective recording of nystagmus elicited by several different stimuli. It is a helpful diagnostic aid, but its exactness should not be overemphasized. There is a large range of normal limits, and many minor variations of the tracings are

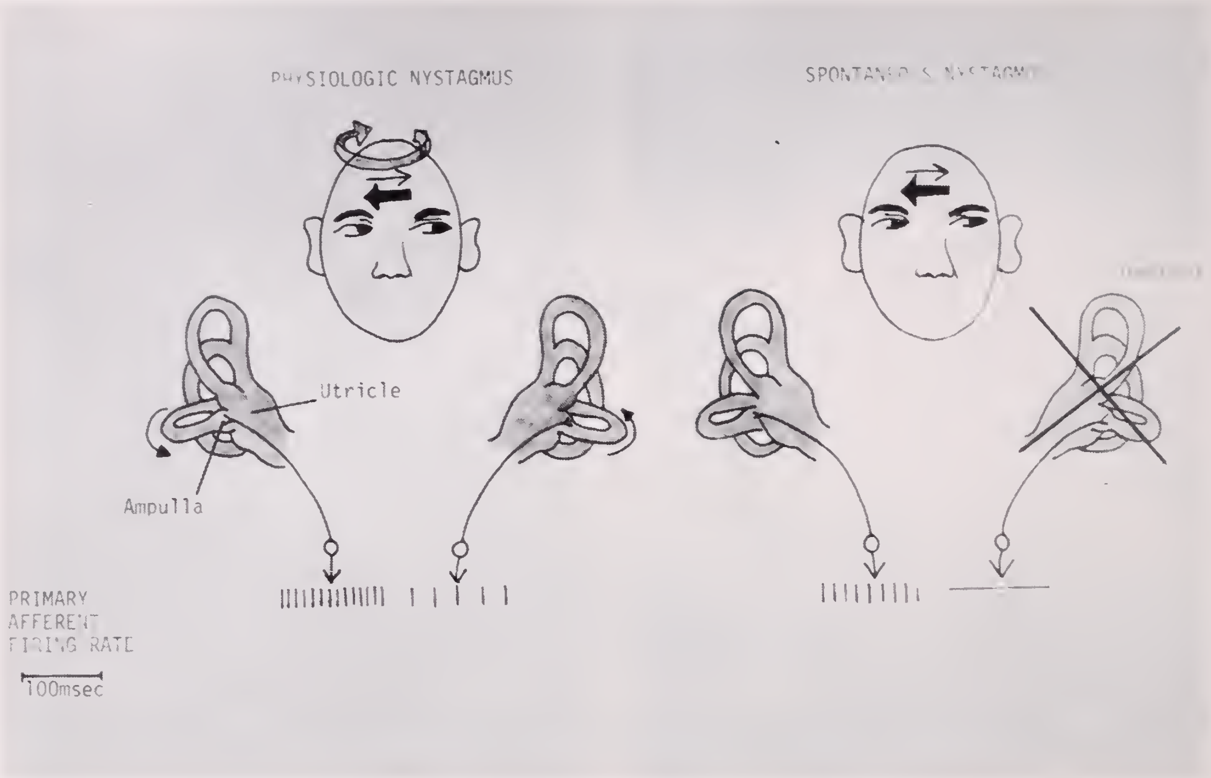


Figure 1.
Physiologic nystagmus induced by movement and spontaneous nystagmus caused by a unilateral labyrinthine disease.

seen; therefore, the examining physician must be familiar with these variations to assure proper interpretation of the test.[1] Remember, this tool is to aid the physician in diagnostic evaluation of the vestibular system, but is not of itself diagnostic.

Differential Diagnosis

The differential for dizziness is extensive and involves many organ systems and disease processes. It is useful to approach the evaluation of dizziness by first sorting the symptoms into one of two catagories: 1) non-rotational dizziness and 2) true vertigo.

1) Non-rotational Dizziness

The ear exam is usually within normal limits with non-rotational dizziness since the etiology of the dizziness is seldom of peripheral origin. (Table I) Cerebral anoxia is the most common cause of dizziness in the elderly patient.[1,3] Common causes of cerebral anoxia include arteriosclerosis, hypertension, orthostatic hypotension, anemia of any etiology, sustained cardiac arrhythmias, aortic stenosis and/or insufficiency, complete heart block, and carotid sinus hypersensitivity.[1,3] Evaluation should include a physical exam with blood pressure evaluation (both suprine and upright), CBC with differential, and ECG. Prolonged cardiac rhythm monitoring may be necessary, such as with a 24 hour Holter monitor.

Metabolic abnormalities, such as hypoglycemia and hypothyroidism are common causes of dizziness. Hypoglycemia might be suspected if the history reveals a relationship between dizziness and food ingestion.[1] A five hour glucose tolerance test or a 2 hour post prandial glucose test are sometimes helpful.

Infections of the CNS known to cause dizziness include meningitis, encephalitis and syphilis. Increased CSF pressure has many etiologies including tumor, trauma, infections, congenital malformations, and can itself cause dizziness. However, dizziness alone seldom leads to the diagnosis of a brain tumor since other symptoms are more localizing and characteristic.[1]

Tabes dorsalis, pernicious anemia, and

pellagra are rare diseases affecting the proprioceptive system that may cause dizziness. The FTA-ABS test, CBC with differential, and a thorough neurological exam coupled with the associated symptomatology (i.e., the manifestations of vitamin deficiency, diarrhea, and dermatitis present with pellagra, or the pallor and extremity numbness associated with pernicious anemia) should assist with making the correct diagnosis.[1]

2) True Vertigo

True vertigo causes a sensation of motion such as whirling, propulsion, or the feeling of falling and is caused by endorgan, eighth cranial nerve and brain stem lesions.[3] (Table I)

Table I: Differential Diagnosis of Non-rotational Dizziness and True Vertigo

NON-ROTATIONAL DIZZINESS
- Cerebral Anoxia
- Metabolic Abnormalities
- Infections of CNS
- Increased CSF Pressure
- Proprioceptive System Disease

TRUE VERTIGO
- Meniere's Syndrome
- Benign Paroxysmal Positional Vertigo (BPPV)
- Vestibular Neuronitis
- Syphilis
- Trauma
- Acoustic Neuroma
- Multiple Sclerosis

Meniere's syndrome (endolymphatic hydrops) is a common cause of vertigo; however, it is much too often utilized as the "wastebasket" into which cases of undiagnosed dizziness are dumped.[1] Adherence to the following definite criteria will decrease diagnostic errors and increase the chance of a correct diagnosis: 1) whirling vertigo lasting hours not days, 2) fluctuating but progressive hearing loss, 3) tinnitus and 4) aural fullness.[2]

Vertigo is the most disabling symptom in Meniere's syndrome and is frequently the reason the patient seeks medical attention. The sensorineural hearing loss is unilateral 80% of the time and is classically in the low frequencies.[1] The tinnitus associated with Meniere's is normally nonpulsatile, frequently fluctuates, and is often continuous between attacks. Its magnitude is roughly proportional to the degree of hearing loss.[1] While not listed in some texts as a criteria for Meniere's disease, aural fullness is an important clinical manifestation. This fullness is constant, often is the first symptom noted by the patient, and ear examination, including tympanometry, shows no abnormalities.[1,4] Tension and anxiety have been known to precipitate the attacks of vertigo. Non-specific symptoms such as nausea,, vomiting, pallor, tachycardia and diaphoresis are common.

While it is known that Meniere's disease is an abnormality of the inner ear, its etiology is unknown. Theoretically, the hydropic distention of the endolymphatic system of the inner ear causes Reissner's membrane to rupture, allowing endolymph and perilymph mixture with the resultant electrolyte imbalance precipitating an attack. While children can be affected, symptoms normally begin between the second and sixth decades. The disease is unilateral in 70-80% of the cases,[1,5] affecting men and women equally.

Functional testing for Meniere's includes electronystagmography (ENG) from which the most common finding is horizontal nystagmus and a hypoactive response to caloric stimulus. Temporary improvement of the low speech frequency hearing threshold and discrimination score after the ingestion of glycerol indicates that the patient may very well benefit from an endolymphatic shunt operation to relieve the symptoms of the disease.[1,5] The BSER audiogram can help differentiate a patient with Meniere's disease from one with an acoustic tumor. Allergy testing may reveal a non-IgE mediated allergy to inhalant or food allergens which comprise approximately 10-15% of the individuals suffering from this disease.[1]

Medical management of Meniere's disease can be preventive or symptomatic. Preventive management attempts to prevent the occurrence of vertiginous attacks; however, it has not been shown to alter the progression of hearing loss nor arrest the degenerative course of the disease.[1] Our treatment protocol includes: 1) low sodium diet, 2) abstinence from caffeine and nicotine, 3) Dyazide 1 q day, 4) Robinul Forte (anticholinergic) 2 mg b.i.d., or 5) Ru-Vert (meclazine HC1) 3 mg. t.i.d. to relieve the nausea, vomiting and dizziness.

Symptomatic relief of Meniere's is required to control the effects of the disease after vertiginous attack has begun. Good results have been obtained using Valium 5 mg. t.i.d. or Centrax 10 mg. t.i.d. for the ambulatory patient. Intravenous titration of Inovar (Droperadol plus Fentanyl) every 30 minutes as needed has also been proven helpful for the patient who is bedfast and unable to tolerate oral fluids or medications due to the nausea and vomiting that often accompanies the severe attacks of Meniere's.[4]

Streptomycin can be used to treat bilateral disease that is not responsive to more conservative theraphy. In carefully monitored dosages, this ototoxic drug ablates mainly the type I hair cells of the semi-circular canals and otolith organ while not significantly impairing the patient's hearing.[1] The patient is treated until no response to calorics is obtained.

Neither preventive or symptomatic management of Meniere's disease significantly alters the course of this disease. The goal of treatment is to allow the patient to function as normally as possible with minimal disability and decreased frequency of the episodes.

Should medical management fail, Meniere's disease is frequently responsive to conservative or destructive surgical treatment. There is currently a trend toward earlier surgical intervention in an attempt to prevent the progressive hearing loss which eventually ensues with medical management.[5] These surgical methods are not without their risks; however, it is not always easy to know which procedure will be the best one for the individual patient.[1,5] The most conservative operation for Meniere's is the endolymphatic shunt. Since the symptoms of Meniere's are secondary to increased endolymphatic pressure causing distention and membrane rupture within the endorgan, shunting operations often prove beneficial.[1,5] The endolymphatic shunt involves placing one end of a small silicone shunt into the endolymphatic sac and placing the other end into the mastoid or subarachnoid space. (Figure 2) This potentially relieves the pressure of the endolymphatic space that occurs during a Meniere's episode, thus preventing an attack. This procedure does not destroy the labyrinth or cochlea and relieves the symptoms of this disease in 50-70% of the patients.[1,5]

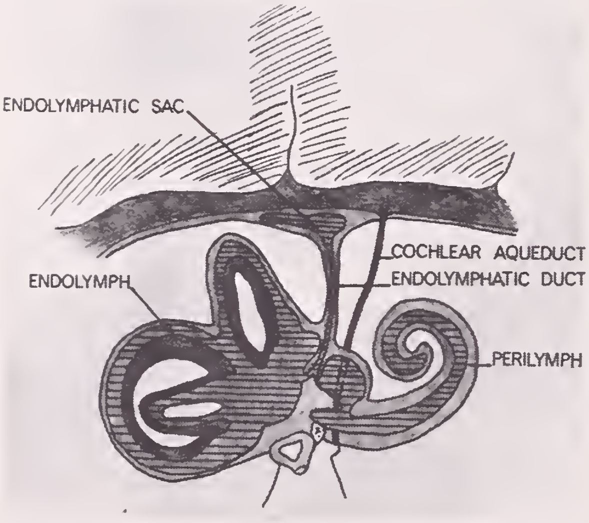


Figure 2.
Location of endolymphatic sac in relationship to labyrinth, cochlea and brain tissue.

Two destructive surgical procedures available for the treatment of Meniere's are the vestibular neuronectomy and the labyrinthectomy. These procedures are destructive in the sense that a neurologic system is irreversibly altered by the operation, although they can provide significant relief to the patient. The labyrinthectomy is reserved for patients with only unilateral disease and with little or no serviceable hearing in the diseased ear.[5] The vestibular neuronectomy via cranitomy approach involves transecting the vestibular portion of the vestibulo-cochlear nerve, thereby relieving the symptoms yet preserving hearing. Vestibular neuronectomy and labyrinthectomy are permanent procedures which require careful decision making and patient counciling preoperatively.

Benign paroxysmal positional vertigo (BPPV) was described by Barany in 1921 as a sudden onset of vertigo and nystagmus in the supine position with the head turned so that one ear is lower than the other.[1] One to five seconds after the patient assumes the "critical position," a violent vertiginous episode occurs lasting 10-20 seconds and then suddenly fatigues. Adaptability is characteristic of BPPV and is noted upon repeated instigations of the episode as each consecutive attack becomes shorter in duration and less severe. A positive Dix-Halpike maneuver, i.e. stimulation of the dizzy response by a series of standard maneuvers, is diagnostic of BPPV.[1] Treatment is supportive, and reassurance should be given to the patient that the normal recovery time of this disease is six weeks to six months, and most likely they will recover uneventfully.

Vestibular neuronitis (labyrinthitis) is clinically unique in its presentation. It is characterized by an acute onset of nausea and vomiting, spontaneous nystagmus away from the diseased ear, but no auditory signs or symptoms. The patient is often violently ill and bedridden for three to seven days since any movement aggravates the symptoms.[1] Auditory exam shows no hearing loss; the caloric test shows decreased to absent response in the diseased ear even after the patient has fully recovered.[1,3] Recovery is gradual with daily improvement over a three to six week period. Although the etiology is unknown, this type of vertiginous disease is often epidemic and many times follows an upper respiratory tract infection indicating a possible viral etiology.[1] Treatment is symptomatic and supportive requiring hospitalization for intravenous hydration, sedation and antiemetics.[4]

Tertiary syphilis (lues) can manifest itself much like Meniere's disease. The vestibulocochlear manifestations are secondary to the endolymphatic hydrops and obliterative endarteritis affecting the bony otic capsule. An autoimmune response is also thought to play a role in this disease.[4] The disease involvement is usually bilateral, and caloric testing will show a hypoactive response. Diagnosis of tertiary syphilis should be done via the FTA-ABS test, as it will be positive in 95% of the cases while the VDRL test is positive in only 60-70% of tertiary cases.[1,4] The recommended treatment for tertiary syphilis is Bicillin LA 2.4 million units per week for three weeks. Prednisone is given daily for three weeks and then reduced to an alternate day schedule at a dosage that will keep the symptoms to a minimum and hopefully restore some of the hearing loss. Alternate day steroids will help avoid adrenal suppression and a morning dosage schedule is usually preferred.[1,4]

A history of trauma should not be overlooked. The patient who has suffered from a whiplash injury may have partial impingement of the vertebral arteries or cervical muscle spasms and may cause both dizziness and true vertigo.

Temporal bone fractures are present one third of the time in patients with basal skull fractures. Of these, 25% will involve the labyrinth and can cause vertigo.[1] Vertigo secondary to trauma usually manifests itself with nausea and vomiting and spontaneous nystagmus. The treatment in most cases can be supportive utilizing antivertiginous medications, heat, massage, muscle relaxants, and a soft cervical collar, while waiting for central nervous system compensation to occur.

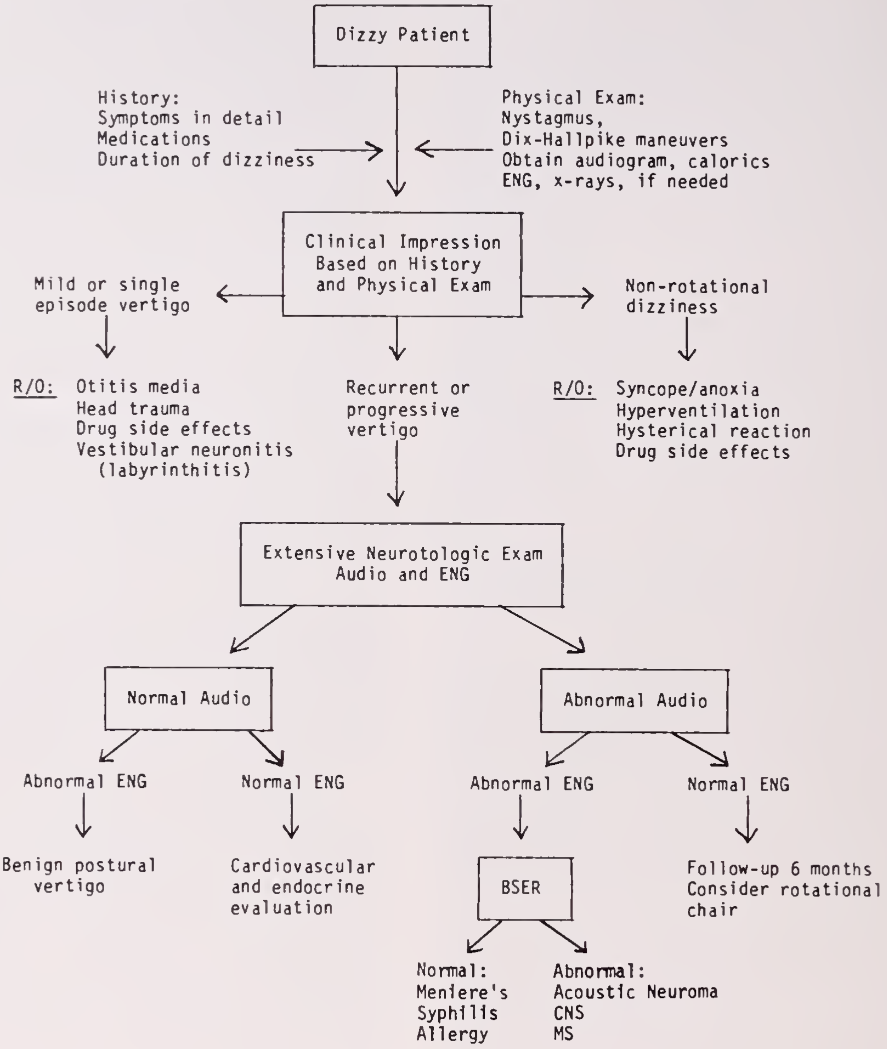
Acoustic neuroma (schwanoma) is an uncommon cause of true vertigo, but its presentation may be mistaken for Meniere's disease. Acoustic neuromas are histologically benign and are the most common tumor of the posterior cranial fossa. This slow growing tumor classically presents with unilateral hearing loss, tinnitus and unsteadiness or dizziness.[1,4] If suspected, the evaluation should include audiometric studies, BSER, and CT scan of the temporal bones. Treatment is surgical excision by either translabyrinthine or middle cranial fossa approach according to the size of the tumor.[3] Early diagnosis is the key to successful management of this tumor, since late intervention assures multiple cranial nerve involvement secondary to surgical removal.

Multiple sclerosis (MS) is a cause of vertigo that should be suspected if dizziness does not fit the diagnosis of other etiologies and the history reveals other neurological symptoms which have occurred suddenly and then spontaneously resolved. Seven percent of patients with MS present with vertigo as the initial symptom, with 11% developing it as a later symptom.[1] MS manifests itself as multiple lesions separated in time and space causing different symptoms at different times. Transient blindness, diplopia, incontinence, numbness and vertical nystagmus are often presenting signs. Most patients present with MS in the third decade of life. It is very easy to miss this diagnosis unless the physician remembers to include it in the differential.

Summary

The evaluation and treatment of the dizzy patient requires a careful, complete history and physical exam while looking and listening for key pieces of information which help lead to the correct diagnosis. Separation of vertigo (a sensation of whirling, propulsion, or falling) from non-rotational dizziness (a sensation of disorientation in space or light-headedness) should be the first step in the evaluation. The

Table II. FLOWSHEET FOR DECISION MAKING IN DIZZINESS



great majority of disease processes involving true vertigo imply involvement of the vestibulocochlear endorgan while the most common cause of non-rotational dizziness is cerebral anoxia. The examining physician must be aware of the possible influence of systemic disease in the production of dizziness. Strict adherence to the criteria for Meniere's disease will decrease over-diagnosis of this disease and allow for the correct evaluation and treatment of the patient. Nystagmus is an important finding to help differentiate between central (vertical nystagmus) and peripheral (horizontal nystagmus) etiologies of dizziness. The availability of a basic differential diagnosis flowsheet[6] (Table II) in conjunction with an accurate medical history will serve to streamline an organized, systemic approach to the evaluation and treatment of the dizzy patient.

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H. Winnett Orr and the Nebraska Orthopaedic Hospital

Supported by a grant from the Nebraska Orthopaedic Society

HIRAM Winnett Orr was born in West Newton, Pennsylvania in 1877. The family decided that this child, if a son, should study medicine following in the footsteps of his uncle, Dr. Hudson J. Winnett, who had agreed to help with the boy's education.[1]

Orr graduated from high school in 1892 at the age of 15. He was given $500 by his grandfather with the understanding that he would live with his uncle in Lincoln and take premedical courses at the University of Nebraska.

Upon completing his premedical training Orr then entered the Medical College of the University of Michigan at Ann Arbor. In 1899, at the age of 22, he received his medical degree from that institution. He noted proudly in his journal that his seven years of training at the two universities had cost less than $300 per year, due mostly to his stringent economies. Orr intended to stay in Michigan for further training, but Dr. Winnett's health had deteriorated during his absence. His uncle requested that Orr return to Lincoln and take over some of the medical practice, and Orr responded to that need and returned to Nebraska.

Several years in general practice with his uncle reinforced Orr's desires to train for a specialty. In 1904, he took a few months leave from his practice and moved to Chicago with the intention of specializing in pediatrics. While in Chicago, however, he encountered Dr. John Ridlon and was immensely impressed with his work. Ridlon persuaded Orr to train for orthopedic surgery and he remained in Chicago for the summer as a student of Ridlon's.

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Founding of the Nebraska Orthopedic Hospital

When Orr returned to Lincoln in the fall of 1904, he found a favorable climate for the practice of his new specialty. During his absence, Dr. Lenore Perkey, a homeopathic practitioner, had stimulated public interest in the care of crippled children. Perkey was a physician at the Nebraska Home for the Friendless, an institution founded in 1876 by the "charitably inclined" women of Lincoln to care for orphans, unwed mothers, and "homeless old ladies."[2]

An inmate at the home, a York county orphan named Carrie Bacon, aroused Dr. Perkey's sympathy. Carrie suffered from a congenital defect of the spine and hip joint which caused partial paralysis. She had spent most of her years at the county poorhouse. When her condition became critical, she was sent to Omaha for surgery, where her feet were amputated. She was then shuttled back and forth between the York County institution, the hospital in Omaha, and the State Home for the Friendless. Her stumps had not healed properly, and the little girl was in constant pain. Dr. Perkey, reviewing Carrie's case, found that while the state provided for the treatment of deaf, blind, and retarded children, no provision was made for the crippled. Such children were placed in county poorhouses where they received no specialized care for their problems and no education. Carrie was being passed from institution to institution because she did not meet the guidelines for permanent residence at any of the existing facilities.

In an attempt to arouse concern for the plight of such children. Dr. Perkey presented a paper on the subject at the May, 1904 meeting of the Nebraska Homeopathic Medical Society. Citing the examples of New York and Minnesota, which had provided state facilities for the care of crippled children, Perkey called for a similar legislation in Nebraska. The Society responded to the challenge by appointing a committee, headed by Perkey, to draft a bill for presentation to the state legislature. The bill requested funds for a state-supported facility for the care, treatment, and education of crippled children.

Perkey moved rapidly in soliciting support for the measure. She secured the aid of several prominent members of Lincoln society and the interest of the press. When Orr returned to Lincoln in August of that year, a chance street corner encounter with Perkey led to his involvement with the campaign. Orr recalled that "when Dr. Perkey came to me with her 'homeopathic' proposition, my first move and before committing myself to her, was to consult twenty of the 'regular' physicians practicing in Lincoln." He received no encouragement from his colleagues. As he noted: "The feeling between the regulars and the homeopaths was still pretty strong in those days." Most objected to Orr's involvement with Perkey and refused to support the project.[3]

The drive continued to gain momentum. Two prominent homeopaths, Dr. E.B. Finney and Dr. E.A. Carr, lent their support, as did Lincoln socialite, Mrs. L.W. Pomerene; Miss Cora Garber, daughter of a former governor and member of the State Press Association; John Davis, Secretary of the State Board of Charities; and J.H. Casebeer, a legislator from Gage County. As editor of the **Western Medical Review,** Orr continued to solicit the support of the medical profession. A sympathetic press provided widespread, favorable publicity, using pictures of the pathetic Carrie Bacon to arouse public sentiment. The campaign wisely appealed to the conservative instincts of Nebraskans by stressing that proper care and education would enable many crippled children to become productive and self-supporting, instead of remaining lifelong economic liabilities to the State. Echoing the idea of economy through rehabilitation, Orr wrote in the **Western Medical Review:** "The little one who is deformed is often unusually acute mentally . . . Many a child apparently doomed to lifelong invalidism or early death may be transformed from a helpless into a helpful individual by the skilled orthopedist."[4]

While Nebraskans were concerned with the plight of Carrie Bacon, another crippled child, Lolita Armour, was attracting nationwide attention. Lolita, of the prominent Chicago meat-packing family, suffered from a double congenital dislocation of the hip. Ridlon had operated on one hip—unsuccessfully—and the Armours had persuaded the famed Dr. Adolph Lorenz of Vienna to come to Chicago and operate on the other hip. Lorenz was promised a large fee. His trip was widely promoted by the press as he and his associates traveled from New York to Chicago stopping for numerous consultancies and surgeries. Orr reported that "the total of fees collected by Dr. Lorenz and his associates, during his few weeks in this country, was close to a million dollars." Lorenz's journey and its attendant publicity did serve to acquaint the public with the specialty of orthopedic surgery during the same months that the Nebraska committee was promoting the establishment of a hospital for the treatment of such children.[5]

Representative Casebeer presented the bill asking for $25,000 for the state orthopedic facility in the fall session of the legislature. The measure drew great resistance from conservative legislators. After much discussion, the appropriation was cut to $10,000 and the bill finally was approved, only to be vetoed by the governor. Governor Mickey justified his action on the grounds that he had lived in Nebraska for twenty years and had not seen as many as twenty crippled children in all that time. In response to the governor's remarks, the committee quickly surveyed the two or three counties surrounding Lincoln and found seventy-eight crippled children residing in county poorhouses. They estimated many times that number were housed in private homes and other institutions. None were receiving adequate medical care. At this point Governor Mickey conceded to public pressure and signed the bill—in April, 1905.

The original amount of $25,000 had included funds for the construction of a facility, but the reduced amount of $10,000 ruled out that possibility. The state finally decided to locate the new orthopedic hospital in the basement of the State Home for the Friendless, the institution with which Perkey was associated. Orr remarked that the matron of the home was "quite frank about her lack of enthusiasm for the project," viewing it as "obviously designed to disturb the routine of her institution and her affairs."[6]

Nebraska Orthopedic Hospital: 1905-1917

The Nebraska Orthopedic Hospital, opened in 1905, was the third such facility in the United States. Minnesota established the first hospital in 1897. New York followed in 1900. The chief surgeons of these institutions, Dr. Arthur Gillette of St. Paul and Dr. Newton Shaffer of New York, had helped considerably in drafting the bill, as had Dr. John Ridlon, Orr's mentor in orthopedics. On the advice of these and others, the Nebraska bill specified that the chief surgeon and superintendent of the hospital be appointed by the Board of Commissioners of State Lands and Buildings. This board and not the governor's office, was to administer the affairs of the new hospital. This structure was designed with the hope of reducing political pressure on those involved with the institution. The bill's sponsors also sought to eliminate the prospect of a governor filling the administrative positions at the hospital with political cronies. Seeking the most qualified physicians to fill the new positions, the board invited Dr. J. P. Lord of Omaha to act as chief surgeon, at a salary of $1,200 per year. Orr was asked to be the on-site superintendent and assistant physician, at a salary of $600 per year.

The hospital admitted its first patient in October, 1905. The patient was Carrie Bacon, whose case had instigated the drive for the facility. Carrie, confined to a wheel chair, remained at the hospital for a number of years.[7] Lincoln's "regular" physicians remained hostile to the new institution. Orr mentioned that shortly after the hospital opened, he was suspended from the staff of a nearby hospital for "diverting patients" to the new facility.[8]

Orr and Perkey had worked together effectively, at least in the beginning, to secure passage of the bill. In later years, however, each felt that the other had received undue credit for the accomplishment. Dr. Inez Philbrick, an outspoken feminist of other "radical" persuasions, corresponded with Orr for many years. She frequently took him to task for his sins of commission and omission. In one letter, after castigating Orr for his opposition to socialized medicine, Philbrick related that Perkey had felt slighted and overlooked and was "embittered" that she had not received more credit for her efforts. Perkey had married and moved to Washington, D.C. shortly after the hospital opened. Philbrick conceded that Perkey was shy and unapproachable, but maintained that she was an excellent physician. Rejection by the regulars had hurt her deeply.[9] Orr, on the other hand, wrote shortly before his death that he felt that there had been a "tendency for a long time to minimize (his) part in the initiation of this work in Nebraska."[10]

The hospital was overcrowded almost immediately, admitting 106 patients during the first year of operation. Twenty-five to thirty children were in residence at any given time, in a facility planned for a maximum of fifteen to twenty. The legislature voted the hospital a generous appropriation of $46,000 in 1907, allowing expansion into the first floor of the Home for the Friendless, adding classrooms and another dormitory. Miss Anna Hardwick, trained in orthopedic nursing at the New York hospital, was the head nurse. Miss Hardwick initiated and administered a nurses' training program, which continued for several years until state regulations forced discontinuation of the school.

The relationship between the Home for the Friendless and the Orthopedic Hospital worsened as the hospital took over more of the home's territory and received greater attention from the public. The two institutions were finally separated in 1909. The home moved to a different location, and the Orthopedic Hospital took over the entire facility, located at 11th and South Streets.

In 1909, Nebraska was hit by a severe epidemic of poliomyelitis. Most of the nearly 1,000 reported cases occurred in York and Polk counties. Orr estimated that the actual number of cases was at least double the figure reported. Little was known of the disease. Many doctors had never seen a case, so there was great confusion about diagnosis and treatment. Orr sent out questionnaires to families in the two counties, attempting to ascertain the severity of the epidemic. Of the 1,000 recorded cases, about 15% had died of the disease; 15-20% of the victims had recovered completely; and the remaining 60-65% reported at least partial paralysis. The epidemic dramatically increased the demands on the hospital and its staff, especially the need for physiotherapy, braces, and surgery.[11]

The hospital grew rapidly in the first decade of its existence. By 1912, the facilities were severely overcrowded, with an average of 102 in residence on any given day. In 1915, a new wing was added, which provided offices, dining rooms, classrooms, a library, a new surgery, and room for 40 more beds. A year later, in 1916, the number of patients reached an alltime high — there were 732 admissions for the year, with an average of 120 patients in residence daily.

World War I and the Development of the "Orr Method"

In 1917, at the height of the hospital's growth, America entered the First World War. Both Orr and Lord resigned from the hospital staff to enlist in the war effort. Orr joined a medical unit of the American Expenditionary Force. The orthopedic surgeons in the force were sent to Great Britain to be trained in the care of battlefield casualties, Britain having entered the war several years earlier. Under the direction of Sir Robert Jones, the famed British orthopedic surgeon, the American physicians were assigned to various sites for training.[12]

At the British Military Hospital in Cardiff, Wales, Orr saw his first battlefield casualties— "men with huge gaping holes in their arms and legs." He was appalled at the extent of the wounds—wounds of a nature that few physicians would see in civilian practice. He was also horrified at the care of the wounded. Wards were crowded beyond capacity, and more casualties were arriving daily. Few wounds were healing properly: many patients had developed osteomyelitis. Shortage of beds meant that amputees were sent home as soon as their primary wounds healed with the promise that they would be called back later to be fitted for artificial limbs. In 1918, Orr estimated that there were 10,000 such men on the waiting lists, many having waited several years. Of course, many would require additional surgery when they returned and would end up recycled to yet another waiting list.

The conditions Orr deplored in 1917 were a great improvement over 1914, the first year of the war. The British, by rapid attention to and transportation of the wounded, and by experimentation with different forms of treatment, had consistently reduced the mortality rate of wounded men. Mortality from fracture of the femur, for example, was reduced from 60% in 1914, to 12% in 1917.

Witnessing hundreds of cases a day, Orr began to ponder the various forms of treatment. As he noted, the preferred treatment of open fractures and the accepted practices of wound management were "distinctly at odds." Many battlefield casualties presented both problems simultaneously. Orr reported: "All forms of treatment were being subordinated to the irrigations, flushings, and packs, with all the kinds of chemicals, old and new, that were being tried out . . . orthopedic principles were being set aside."[13] Orr came to the conclusion that the wrong alternative had been chosen— better results would be obtained if rest and immobility were considered primary and wound treatment secondary. He theorized that a thorough cleansing of the wound followed by packing the cavity with a sterile dressing and applying a splint or plaster cast would result in less tissue damage and risk of infection than use of the irrigation method, while allowing the fracture to knit effectively.

In July 1918 Orr was assigned to the American Forces in France. What was to have been a few weeks in a British hospital had lasted for over a year. From his headquarters at Base Hospital #9 in Savenay, Orr served as orthopedics consultant for area hospitals. One of his primary duties was to approve wounded for transfer home. In this capacity, he hoped for a chance to try his theories of treatment.

Like the British hospitals, Savenay has innundated with casualties. In eight months Orr's orthopedic unit treated 18,000 patients. Here Orr saw for the first time the "Balkan frames, weight and pully traction, and the elaborate apparatus" which had become the preferred American treatment for fractures. He found that patients were treated in . . . such a way that the injured, damaged and inflamed limbs were never at rest at all."[14]

To Orr's surprise he found the American Army surgeons completely unreceptive to any suggestions. He found himself ridiculed and thwarted in his efforts to implement any changes in the treatment of wounded. Leigh White, writing for **Harper's** in 1943 described Orr's experiences:

"When Orr proposed enclosing fractured limbs in plaster, regardless of their infection and secondary wounds, he met with a storm of protest. His colleagues assured him that he would be condemning his patients to death, that they would all die of infection before they reached the United States. But he was finally permitted to make his experiment, with the understanding that if any of his patients died, he would be tried before a military tribunal.

With some misgivings he sent his first group of patients home in plaster. On the cast of each he wrote in ink his diagnosis of the case, with instructions not to remove the cast or cut a window in it to treat the wound unless the patient's fever had risen to a dangerous level. He also gave his home address in Lincoln to each of his patients, and asked them to write to him from time to time, reporting on their progress.

The results of his experiment were startling, even to Orr himself. He received letters from several hundred of the men he had sent home in plaster. Those whose casts were left untouched reported that their wounds had promptly closed. Unfortunately, they were in a minority. Officious orderlies and surgeons on the hospital ships had usually disobeyed his instructions and cut windows in the plaster casts, or removed them altogether, in order to change the dressings of the wounds and treat them antiseptically. These latter patients reported that their fevers had risen as soon as their casts were removed, and that their wounds had either never healed or that healing had been long delayed."[15]

Early in 1919, when fighting had ceased, Orr was reassigned to the United States. After a brief stay at Walter Reed Army Hospital in Washington, he was sent to Fort Des Moines. He was finally discharged in the summer of 1919. Orr found that neither the Army nor the civilian physicians were enthusiastic about his treatment. At Walter Reed, where "the most elementary rules were being disregarded for the care of amputation," he was told that "we do not want any advice from the British and French as to the care of our patients." Civilian physicians, generally speaking, resented the new "experts" who were returning from the war, although the latter had probably examined more patients in their few years of service than many physicians would see in their lifetime. Furthermore, those who had worked at field hospitals had encountered patients whose wounds were of a severity unknown in civilian practice.

The "Orr Method" and the Nebraska State Orthopedic Hospital: 1918-1935

Dr. Lord was apparently not interested in renewing his affiliation with the Orthopedic Hospital, and Orr was appointed as chief surgeon of the institution. The average number of patients in residence had declined from the 1916 figure of 120 to 64 in the 1918-1920 biennium. Orr now concentrated his energies on his work at the hospital, rebuilding his private practice, and implementing and publicizing the "Orr Method."

American physicians remained skeptical and often hostile to Orr's ideas. When Orr first published his results with the treatment in 1923, a prominent Boston surgeon dismissed the idea as nonsense, and "others went so far as to denounce him as a quack."[17] Orr himself remarked that his ideas were widely misunderstood: "Many supposed that I was the champion of a new and unorthodox cure . . . and that I thought that either the plaster cast or the vaseline dressing had some previously undiscovered curative powers . . . the fact is that my proposal was for a treatment program, the principle feature of which was that several harmful items of treatment in general use were **left out**."[18] Even Ridlon, predisposed as he was toward Orr, remained somewhat skeptical. A draft of the 1923 paper sent to Ridlon for critical appraisal was returned to Orr with very cautious approval and suggestions for modification.

Orr wrote, lectured, and performed demonstrations of his technique in Lincoln and wherever he was granted an audience. Even those few who approved of his method in theory seemed unwilling to employ it in actual practice; Orr's friend, Dr. Arthur Steindler of Iowa City, was a good example. Passing through Iowa City on his way east, Orr treated one of Steindler's patients with acute osteomyelitis of the foot, a patient upon whom Steindler was preparing to perform an amputation. Orr ordered Steindler not to touch the cast until he came back through Iowa City several weeks later, at which time the patient was recovering nicely. Steindler, although finally convinced of the value of the treatment, still objected to it on aesthetic grounds.[19]

In truth, there was much to object to. Most physicians of the day detested working with plaster, shuddered at the idea of pounding pins and spikes into arms and legs, and violently objected to the sight and smell of plaster cast soaked with drainage from the wound. Orr did concede that the cast could be changed when the patient became so objectionable that no one could stand to be near him, but he recommended waiting as long as possible.

Orr read a paper on his treatment at the 1928 meeting of the American Orthopedic Association. Although the majority of his audience registered disbelief and disapproval, Sir Robert Jones was present and spoke on behalf of the treatment, linking it with his own methods and those of the illustrious Hugh Owen Thomas. Encouraged by Jones' advocacy, Orr presented the paper to the Boston Orthopedic Club, where he was impolitely handled. One prominent surgeon, derisively labeling the treatment "Orr's grease method," told Orr that he was acting in complete violation of surgical principles. Dr. Charles Scudder, another prominent surgeon present at the meeting, "positively shuddered when he was told what I was doing," wrote Orr. "He warned me at once **never** to put any patient with an acute bone infection into a plaster cast. When I told him I had been doing so right along, he lifted his hands and rolled his eyes heavenward," at a complete loss for words.[20]

As Jones support indicated, Orr's method was received much more favorably abroad. The war experience of the British had convinced them that the Carrel-Dakin irrigation treatment then in vogue left much to be desired. A Spanish physician, Dr. J. Treuta, had publicized a similar method of treatment, developed in the Spanish Civil War. The Russians, also, were experimenting with similar ideas. Actually, there was a historical precedent for such methods in Russia. During the Crimean War a Russian physician named Pirogoff had used a closed plaster cast treatment for open fractures, and in the 1920's a Dr. Silva had revived Pirogoff's method. Orr's work received highly favorable reviews in Russian medical journals. Orr commented that, as usual, the Russians were trying to take credit for originating everything.

Orr received many invitations from abroad, and he lectured and gave demonstrations in Paris, London, Dublin, Bologna, Vienna, and other cities. American orthopedists, whether they agreed with Orr or not, were forced to accept the fact that his and similar methods were becoming the preferred forms of treatment abroad.

The American popular press discovered Orr from the European publicity given the "Orr Method." **Life** published a feature on the treatment in 1940, and Leigh White's **Harper's** article appeared in 1943. White, an American correspondent covering the Spanish Civil War, was severely injured in a bombing incident. Having read of Treuta's method, he begged his physicians to use it, to no avail. His injuries healed poorly, and he remained in considerable pain. Upon his return to the United States, White contacted Orr and traveled to Lincoln for surgery. While a patient at the Orthopedic Hospital, he wrote the story of Orr's experiences for **Harper's**, adding a plea of acceptance of the method by American military personnel in the current war, World War II. Although the British and French had adopted the treatment by the beginning of World War II, the method was not used initially by American Army surgeons.[21] Subsequent World War II experience, however, led to the Orr-Trueta method becoming widely adopted for most military wounds.

In 1935, Orr and other prominent orthopedic surgeons were invited to join Franklin Delano Roosevelt's campaign against infantile paralysis. In September of that year, Orr received a telegram from the Warm Springs Foundation on behalf of the President, who was then traveling by train to California. FDR requested that Orr meet with him in California to "discuss the perfecting of a nationwide attack on infantile paralysis." Orr at that time remembered that he "had more invitations than he could accept," and was not eager to spend the money, Nor was he, we gather, an ardent admirer of FDR. At any rate, Orr cabled the President that he would be unable to attend the meeting. The following day Orr received a frantic call from the governor of Nebraska, who explained that FDR's invitation was in fact a "royal command." When Orr repeated that he did not intend to go, the governor replied: "You can't **do that**!" The governor offered financial assistance and persuaded Orr to accept the invitation. Orr traveled to San Diego, where some thirty other orthopedic surgeons were also in attendance.

The group was astonished at the extent of FDR's disabilities. Nevertheless, Orr noted that as soon as the Presient began to speak, his physical condition was forgotten. His "charm" of manner, and his very great force as a speaker were such that we were entirely sold on the program and on the President," wrote Orr. The physicians were surprised, however, that FDR asked for no advice or suggestions from the assembled company, "all of whom had had years of experience in treating the disease, and many of whom had done extensive preparation for the conference." After about one hour the meeting was over, and the physicians left for home.[22]

The Nebraska Orthopedic Hospital: 1936-1955

Many Nebraska children continued to be treated at the Orthopedic Hospital during these years. In 1935, provision for the care of indigent children was organized under the control of the State Welfare Bureau, which assumed responsibility for administering funds and overseeing care of crippled children in Nebraska. As a result of the reorganization and in response to FDR's campaign against infantile paralysis, the hospital began an outreach program, sponsoring clinics throughout the state. The Welfare Bureau hoped to increase awareness of the disease, decentralize activities, and provide treatment for children in their own counties whenever possible. Orr found the clinics to be idealistic and not very practical. He wrote: "It was only a few months until the work was costing two to three times as much as the same kind and amount of work had been costing up to that time."[23] The relatively unsuccessful experiment was sharply reduced after a year or so, and most subsequent treatment was administered in Lincoln or Omaha.

In 1947 Dr. Fritz Teal was appointed Chief Surgeon and Dr. W.R. Hamsa Associate Surgeon of the Orthopedic Hospital. Orr remained as senior consultant. He was less than enthusiastic about the multitude of boards, bureaus, and regulations that accompanied the 1935 Child Welfare Act: "There are supervisors, medical social workers, committees advisory and otherwise, so that the machinery of handling these patients has become almost too complicated at times. On the whole, however, the children have been very well taken care of at all stages of their progress through this somewhat complicated machinery," he wrote.[24]

In 1955 the hospital celebrated its Golden Anniversary. A booklet commemorating the event was published. Orr wrote: "Over the fifty years of the conduct of the hospital, something more than 10,000 patients have been received, have been provided with hospital care, schooling, post-operative supervision, and assistance of various kinds. According to our statistics, about 7,500 boys and girls have been rescued from complete or partial disability, and have become self-supporting and independent individuals. To calculate the value of this to the State of Nebraska and to the various communities is quite impossible."[25]

That many of these 7,500 boys and girls held Dr. Orr in great esteem is obvious. The Orr collections at both the University of Nebraska Medical and the Nebraska State Historical Society contain many letters, postcards, pictures, Christmas cards and other memorabilia from former patients. They wrote Orr upon graduation from high school or college, upon getting a desired job, on the occasions of their marriage, birth of their children, and just generally to keep in touch. They seemed certain that he would share their joy in their accomplishments, and would appreciate just how much it meant to them to be leading a normal life. It is also obvious, from the carbons of Orr's replies to them, that he took great pride and pleasure in having been instrumental in enabling these young people to lead happy and productive lives. Orr was, in fact, at work on a book length history of the hospital, and to that end was attempting to locate as many former patients as possible. He died in 1956 before he could complete the work.[26]

Orr traveled widely and published prodigiously. He collected over his lifetime an impressive and valuable library of rare books, many of which are now at the libraries of the Medical Center and the University. His contributions to orthopedics are now recognized in the literature of the field and the Orr treatment. His contributions to Orthopedics are now widely recognized in the literature. The Orr treatment for wounds, as subsequently modified by Treuta and others, has come to be the preferred method of managing wounds in the military experiences of World War II, Korean and the Vietnam campaigns. It still has been less widely accepted by civilian surgeons who seem reluctant to recognize or admit that a method this simple can be effective.

Orr's work brought Nebraska, and especially the Nebraska Orthopedic Hospital, into national prominence. From his student days to the end of his life, Orr remained loyal to his adopted state. One of his first publications was entitled, "The Healthfulness of Nebraska." Leigh White's description of Orr as an "ardent Republican, an ardent golfer, and a life member of the local Chamber of Commerce" perhaps helps to explain why Hiram Winnett Orr and Nebraska suited each other so well.

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1. For details of Orr's early life and student days, see "A Medical Student of the 1890's and of the University of Michigan, Class of 1889," in H. Winnett Orr, **Selected Pages from the History of Medicine in Nebraska** (Lincoln, 1952), and the Orr papers in the University of Nebraska Medical Center (UNMC) Library.

2. Material on the founding of the orthopedic hospital is found in "History of Surgery in Lincoln and Eastern Nebraska," in Orr, **Selected Pages;** H. W. Orr, **Nebraska Orthopedic Hospital, 1905-1955** (Lincoln, 1955); Federal Writers Project, **History of the Nebraska Orthopedic Hospital** (Lincoln, 1941); and in Orr's unfinished ms., "History of the Nebraska Orthopedic Hospital," at the Nebraska State Historical Society (NSHS).

3. Orr papers, NSHS.

4. **Western Medical Review** (Dec., 1904).

5. Orr papers, UNMC.

6. Orr papers, NSHS.

7. The Orr correspondence at UNMC contains an unsigned, undated, handwritten note, telling of the death of "our Miss Bacon," and mentions that she (Carrie) had never been free of pain from her infirmities.

8. Orr papers, NSHS

9. Orr papers, UNMC

10. **Ibid.**

11. See H. W. Orr, "The 1909 Epidemic of Acute Anterior Poliomyelitis (Epidemic Spinal Paralysis) in Nebraska," in Orr, **Selected Pages** and the Orr papers, UNMC and NSHS.

12. For an account of Orr's experiences in World War I, see H. W. Orr, "The Military Experience, 1917-1918," in **Selected Pages;** H. W. Orr, **An Orthopedic Surgeon's Story of the Great War** (Lincoln, 1941); Orr papers, UNMC and NSHS.

13. **Great War,** p. 35.

14. H. W. Orr, **Nebraska Orthopedic Hospital,** p. 28.

15. **Harper's** 186 (March, 1943): 385

16. Orr papers, UNMC.

17. **Harper's** p. 386.

18. H. W. Orr, "Lessons from the Military Experience in the Treatment of Compound Fractures and Other Infected Wounds," in **Selected Pages.**

19. Orr papers, UNMC

20. **Ibid.**

21. Orr writes in one place that the treatment was not adopted by the American Forces in World War II, but in another ms. he mentions that "the United States War Manual for Surgery for World War II devoted many pages to the 'Orr Method' for dealing with all kinds of war wounds and compound fractures." Orr was also somewhat miffed that the treatment was often referred to as the Treuta Method," especially by British medical journals. The British undoubtedly associated the technique with Treuta because after Dunkirk, Treuta was called in to advise Birtish surgeons. Orr felt that he was not receiving enough credit from either the British or Treuta for what he believed he had originated.

22. Orr papers, UNMC

23. Orr papers, NSHS.

24. **Ibid.**

25. **Nebraska Orthopedic Hospital,** 1905-55, p. 40.

26. Orr was buried at the Arlington National Cemetery. Orr and fourteen other eastern Nebraska physicians who served in World War I formed "The Last Man's Club." They pledged to meet each Armistice Day — in full uniform — to hold a memorial service for comrades who had fallen in World War I. The meetings were to be held annually until the death of the "last man". Orr's scrapbook documenting the activities of the group is at NSHS. The "last man," Dr. A. D. Munger, is still alive.

BRIEF COMMUNICATION

Hepatitis B Vaccine for the Family Physician

DANIEL E. HALM, M.D.
Assistant Professor
Program Director,
Residency Training
Department of Family Practice
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

RECENTLY a preventive measure became available that may have family physicians as a potential target population, namely Hepatitis B Vaccine. Family physicians are at low risk for contacting Hepatitis B compared with blood bank workers, pathologists, surgeons and dialysis nurses.[1] Residents in training in an urban Family Practice Residency may represent a slightly different risk because of their exposure to various higher risk specialties (i.e. emergency room, general surgery).

Method

To determine what attitudes were present that might influence a vaccination program, we administered the following questionnaire to all Family Practice House Officers at the University of Nebraska Omaha Campus in January, 1985. Participation was voluntary and of 36 questionnaires sent, 31 were returned:

		yes	no	unknown
1.	Have you had Hepatitis B?	1	30	
2.	Do you feel family physicians in Nebraska should be concerned about their risk of Hepatitis B?	29	2	
	If yes, which factors contribute to this concern			
	a. Potential for transmission to family	25		
	b. Potential for disability from acute infection	24		
	c. Potential for disability from chronic infection	24		
	d. Potential for transmission to patients	20		
3.	Would you accept vaccination with Hepatitis B vaccine as currently marketed?	15	11	4
	If no, why not			
	a. Cost	15		
	b. Risk of unknown	7		

Discussion

Physicians represent a sophisticated group of potential vaccinees. Despite the fact that an overwhelming majority of residents felt that family physicians should be concerned about their risk of developing Hepatitis B, only 50% were willing to receive the currently available vaccine. Although cost was given most frequently as a reason for deferring vaccination, risk of the unknown was a significant concern.

Physicians should be leading advocates of preventive medicine. The dictum of not being the first to adopt something new, or the last to discard something old has served to protect us from many misadventures. This aphorism may explain the seeming hesitance of this group of physicians to receive a relatively new vaccine.

Reference

1. Buynak EB, Roehm RR, Tytell AA, et al: Vaccine against human hepatitis B. J. Amer. Med. Assoc. 235(26): 2832-2834, June 28, 1976.

Letters to the Editor

September 17, 1985

Alan Forker, M.D.
Editor, Nebraska Medical Journal
5505 Ellendale Rd.
Lincoln, Nebraska 68510

Dear Sir:

I wish to add my congratulations to Dr. Gerald Schenken's election to the American Medical Association Board of Trustees.

In the September issue, Dr. Shapiro noted that "never in the long history of the American Medical Association has Nebraska seen one of its members elected as a trustee".

It is noteworthy that Dr. John Tupper, class of '48 University of Nebraska Medical College graduate, is also on the Board of Trustees. This too, I believe, is a first. Congratulations are in order for both of them.

Sincerely,

L. J. Chadek, M.D.

* * *

Robert D. Brown, Ph.D
1200 N. 78th St.
Lincoln, NE 68505

James K. Cole, Ph.D
1960 Richmond
Lincoln, NE

September 27, 1985

Alan D. Forker, M.D.
Editor
The Nebraska Medical Journal
5505 Ellendale Road
Lincoln, NE 68510

Dear Dr. Forker:

This is a response to the article by Paul Cameron, Kay Proctor, William Coburn, and Nels Forde, entitled "Sexual Orientation and Sexually Transmitted Disease" which was printed in the August, 1985 issue of **The Nebraska Medical Journal.** We have concerns which focus on the scientific merit and credibility of the article and with the closing comments in the discussion section of the article. We are also concerned that the **Journal** would permit an author to stray so far from the data presented when discussing the possible implications. Let's look at these in order: scientific merit, credibility of the article, and concerns that a respected journal would provide an outlet and by attribution "scientific respectability" to the data.

Scientific Merit of the Research

Survey research needs to be judged using criteria that considers the representativeness of the sample, the return rate of respondents, validity and reliability of the survey instrument, appropriate data analysis procedures and finally conclusions that are derived from the findings. The Cameron et al. article fails to meet standard expectations for scientific merit on each of these criteria. The failures are plentifold. We will illustrate only a few.

Flaws in the Study

1. **Sampling process.** Criteria for judging the scientific worth of a survey study includes whether or not the sample is respresentative of the population about which the researcher wishes to make inferences. Among the criteria scientists use are the sampling process itself and the return rate. Although Cameron and his colleagues provide specific information on some dimensions of the sampling process, there are also significant omissions. The authors refer to a "systematic area cluster sampling" process, but no information is

provided on how the areas were selected nor how many areas and what neighborhoods were finally selected. Did they sample the cities in some comprehensive manner so that all areas had an equal chance of being in the sample? The authors use the term "conventional one-wave systematic area cluster sampling" without further elaboration on whether any part of the process was random. Vitally important, as well, is what areas were represented in the sample responding to the questionnaire. We are not told much about this, although we are given precise numbers about how many persons responded from each city. Did some clusters respond more than others?

We are also never told why the respective cities (Omaha, Los Angeles, Denver, District of Columbia, Louisville, Bennet, and Rochester) were chosen. Were they a convenient sample? Were they randomly selected? And why were the samples not proportionate to the size of the city (E.g., Omaha is represented with more people in the sample than Los Angeles.)

2. **Return rate.** It is difficult to determine exactly what the return rate was when the authors refer to different "compliance rates" and "return" rates. No matter, the return rate is small. More than a majority of the sample (56.5%) did not complete the questionnaire. When a competent surveyer has a low return rate the credible researcher cautions the reader about the tenuousness of the findings and conclusions. Cameron acknowledges that the respondents' ages were different from the nonrespondents, as were their educational level and race. Neither the small return rate nor the differences between respondents and nonrespondents are noted in any way, however, as a possible limitation to the results and their interpretation. It is disturbing when researchers draw conclusions on the basis of a return rate of less than 50% on such an important issue. Experienced and qualified researchers would not base any definitive conclusions on such a limited return, and if they did, they would note the limitations of their study and the possible lack of generalization of their findings.

Questions about the representativeness of the sample apparently occurred to the authors. On page 297, they note "our sampling method was somewhat biased toward soliciting homosexuals." We wonder how and why? The authors comment on the same page, "The police were called at least once in every city in which we interviewed and it is our impression that sexually conservative people were more apt to refuse to cooperate." This is the first we have heard in our research experience that "impressions" are acceptable and credible data. Again, on the same page, "our estimates are more representative than the various magazine or Kinsey sexuality surveys." This is not substantiated with any statistical comparison. Are we again to rely on the authors' impressions?

In an attempt to lend credibility to the sampling process, the authors cite comparisons apparently made with a publication by Bell, a prominent and recognized credible researcher on human sexuality. The authors suggest on page 296 that their study and the Bell data "generate almost identical estimates." A personal communication by us with Bell, however, resulted in him commenting that "Neither of the citations made by Cameron establishes incidence rates. Nowhere could anyone get those from the books." Bell, the primary author of the books, said Cameron has misrepresented the data.

Thus, we have a low return rate from a sample that the authors admit was biased. These are not the usual ingredients of credible scholarship.

3. **Instrumentation.** Another concern is the questionnaire. Indeed, the questionnaire is lengthy (550 items) as the authors note. Undoubtedly the length as well as the nature of the questionnaire played a role in the low return rate. Experienced researchers know that persons who respond to a 550 item questionnaire on a voluntary basis are probably different from those who do not. That raises questions about the validity and reliability of the questionnaire. Did the questionnaire measure what it was supposed to measure? Did the respondents answer honestly? The authors report no information on how valid the questionnaire is nor how reliable it is. Do we know that the same persons would have given the same responses if asked to fill out the same questionnaire a week later? How do we know the respondents were not faking their responses? Unfortunately some people enjoy having a bit of fun with researchers and do not respond truthfully. Perhaps a sizeable number of

respondents were having "fun" with these researchers. Any sensible person who has seen this questionnaire which asks quite personal questions about "unusual practices" would question the sincerity, if not the truthfulness, of persons responding. (How many people do you know would voluntarily and honestly fill out a 550 item questionnaire which queried them about highly personal habits and was administered by a stranger who came to the door? The sensible people would be ones who Cameron noted called the police.) Considering the nature of the questionnaire and the data collection process, it is surprising that as many people responded as Cameron reports.

What we have then is an extremely lengthy questionnaire, dealing with highly personal matter and with no cited reliability or validity data, being distributed door-to-door by strangers. In no respectable community of survey researchers would this be characterized as scientific.

4. **Data Analysis.** What happens when the data analysis and presentation are examined? There several major concerns. It appears the data from all communities were lumped together. Thus, for example, the 979 respondents from Omaha (population 300,000) are lumped together with the 934 respondents from Los Angeles (population 4 million). The respondents from the pilot study in Bennett (n=43) and Rochester (n=12) were also apparently lumped in with the rest of the data from larger cities.

No effort was made to control in the analysis for socio-economic differences in the respondents or the cited age and education difference. Were the homosexual and heterosexual respondents in this study equated on these important variables? As Cameron and his colleagues did not apparently control for size of city, we suspect there was no control for socio-economic or other differences. This is an unsophisticated, if not unscientific, approach to data analysis.

Of the 550 questions on the survey, the article presents an analyses on approximately 20-30 items. Why is this? Where is the rest of the analyses? Statisticians know that performing statistical tests on over 550 items will result in approximately 20-30 appearing to be statistically significant just by chance alone. Is this only an interesting coincidence? If you draw cards from a poker deck enough times, you are bound to draw a good poker hand sooner or later. Is this what happened with the analysis of 550 questions?

The step-wise regression is very curiously presented. Relatively little is said in the narrative about the presentation of the data and insufficient information is provided for a full interpretation. How were the variables entered into the equations? There is more than one way to do this. To compare the relative predictive power of the variables, consistent models must be formed for both groups, and then and only then, can appropriate statistical procedures investigate the difference in predictive potency. The relative importance of the findings need to be considered in the context of knowing the respective variances for the two populations (homosexuals and heterosexuals). It is difficult to know the meaningfulness of the step-wise regression without knowing more about how the analysis was performed. As a minimum, insufficient information is provided for interpretation. In fact, from the data presented, it is possible to draw entirely different conclusions than those drawn by Cameron et al.

Thus, the data analysis is curious for its selectivity and its omissions. Even taken at face value, the question, "So what? must be asked. It is like saying that people who go swimming, boating, or otherwise spend time in the water are more likely to drown than those who do not. Those who engage in sexual activities are more likely to contract diseases that are sexually transmitted than those who do not. Is this surprising?

5. **Interpretation of Data** (Discussion Section). A final comment about the article concerns the discussion section. The lack of scientific rigor in the procedures—at least the presentation of them—is disturbing, but perhaps more unsettling is the discussion section which goes beyond the data presented and into other social and psychological issues without citations or foundation from the research. A few examples should suffice: (1) On page 297, the authors equate homosexuality with habits like smoking, drug, or alcohol use. This has no relationship to the questionnaire and is a view that is inconsistent with those expressed by the American Psychological Association and

the American Psychiatric Association. If the authors are going to equate homosexual behavior with "habits," a view incongruent with current research evidence, they should provide corroborating evidence. (2) On page 298, Cameron suggests that homosexuals "claim to have more frequently 'deliberately' infected others." What item on the questionnaire addressed the issue concerned with "deliberate" motivation? Because I sneeze in a crowded room does not mean I deliberately intend to infect people with my cold. It may be irresponsible behavior, but this is not the same as deliberate intentionality. These kinds of statements are prevalent in the discussion section and significantly detract from the scholarly nature of the rest of the articles in the **Journal.** The statements are polemic demagoguery, not those that a serious scholar would make.

Credibility of the Researcher

Cameron's credibility as a scientist whose data and data analyses can be trusted has been seriously compromised by evidence that he has systematically distorted data to support assertions he has made regarding homosexuality. In 1982, in the **Lincoln Star** newspaper, Cameron asserted the dangerousness and criminal nature of homosexuality which he reported was supported by Kinsey data. He was required by the editor to cite the Kinsey sources he used. Careful review of the sources he cited revealed serious distortion and misleading inferences. For example, he used tables of juvenile delinquent and non-delinquent homosexuals and compared them with college and non-college heterosexuals to prove homosexuals engage in relatively more criminal acts than heterosexuals. But he did not reveal to the reader the real nature of the tables he was using, rather he made sweeping conclusions about homosexuality without reservation as to the relevance of his data sources. There were other examples where the percentages he used as "proof" could not be calculated from the sources he provided. It appeared that Cameron selectively used bits of data and tables to prove his contentions.

Perhaps the most disturbing statement made by Dr. Cameron, however, occurred at the University of Nebraska Lutheran Chapel on May 3, 1982. In a tape recording obtained by the **Lincoln Star** newspaper, Cameron is quoted as saying: "Right now here in Lincoln there is a 4 year-old boy who has had his genitals almost severed from his body at Gateway in a restroom with a homosexual act." A **Lincoln Star** article, May 8, 1982, was titled "Cameron Used False Report." This article and articles in the **Star** and **Lincoln Journal,** May 6, 1982, pointed out that checks with Lincoln police indicated that this and similar rumors about a 7 year-old boy and a 14 year-old son of a prominent Lincoln family had no factual basis. Police were reported as "baffled as to the origin of the story." On May 10, 1982, the following editorial statement appeared in the **Lincoln Star.**

"A leading opponent of the proposed Lincoln Human Rights Amendment spreads rumors of an alleged vicious incident calculated to damage the proposal's chances at the polls. When asked about it, he admits the rumor was without foundation. He refused to say from whom he heard the rumor. He says he will not use the rumor again unless he finds it to be true. Nonetheless, he still insists it 'could be true', even through responsible authorities in the city say there is not a shred of evidence such an incident ever took place. The seed is planted, to the contrary."

Thus, unlike most respected scholars, the accuracy of Cameron's data and analysis must be carefully scrutinized. Cameron has been censored by a judge in Texas for presenting misleading testimony. He has been dropped from the American Psychological Association for violating the preamble to its code of ethics. He has been censured by the Nebraska Psychological Association for distorted presentations on homosexuality. (Though Cameron comments publicly that he had resigned from the American Psychological Association prior to being dropped, he fails to note that he was under investigation prior to his resignation. This is like an executive resigning so that he or she will not be fired.)

With this pattern it would be prudent for anyone reading Cameron's "scientific study" to seriously question its credibility.

Concerns for Publication

Finally, we must register our sincere concern that **The Nebraska Medical Journal** would lend credence to such an article, particularly the discussion section of the article.

What do we have left once this article has been pruned of its rhetoric and major sources of invalidity? We have percentages and statistics on a sample that is questionable in terms of its representativeness and based on a questionnaire and sampling procedure of highly doubtful validity. What we have left is gross overgeneralization and misrepresentations of useless data. The evidence presented would not stand up to the scrutiny of competent researchers.

It is unfortunate that the **Journal** has provided a forum for an article that would probably not receive a passing grade in any early graduate course in research methodology or questionnaire design. Between us we have read several thousand student research papers and prospective authors' manuscripts in the past ten years. The publication by Cameron et al. would not pass as a senior research paper or masters thesis in any respected psychology department.

It is unfortunate that the good name of **The Nebraska Medical Journal** will now be cited by Cameron et al. in the future to give credibility to sloppy research at best and gross misrepresentation at worst. This is particularly true when the negative tone of the discussion seems more intended to suggest punishment than compassionate medical treatment you might hope to see in a medical journal. One possible positive side-effect is that now the Cameron data are public, it is possible for everyone to see the study for what it is—useless and questionable data.

Sincerely yours,

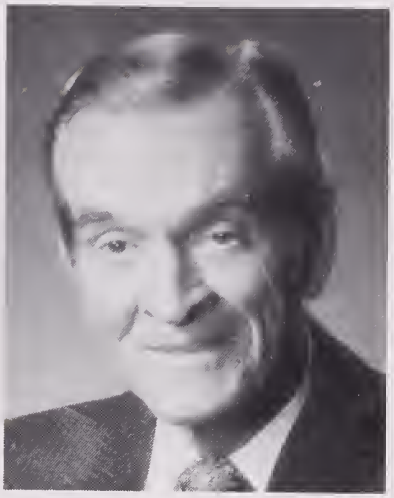
Robert D. Brown, Ph.D

James K. Cole, Ph.D

President's Page

DREAMS AND NIGHTMARES

> "When we have discovered the secret of the atom and can control its force, it is likely all nations will be ready and willing to lay down their arms and abolish their armies and navies. Statesmen will be glad to sit around a table and compromise their differences without any talk of force, for a power will be available in the world so mighty in its potentialities that no person would dare consider its use except for some constructive purpose." (Floyd W. Parsons in the May, 1921, issue of the World's Work)



Francis D. Donahue, M.D.

In 1921, the vast majority of people reading this probably found it believable and took comfort in it's logic. A parallel can be drawn with the events taking place in the health care field starting with the close of WW II. A period of contentment and security bordering on a euphoria developed, at a time now referred to as a "Golden Era," in which all segments of society had easy access to a quality of medical care the world had never before seen. At Hiroshima, Parsons' prediction collapsed and in the early 1980's the golden era of medicine began collapsing.

Beginning the late 1940's, the nation saw a meteoric rise in the availability of health care insurance. From 1945 to 1960 the number of insurance policies for hospital care increased from 32 million to 122 million and policies for physician expenses rose from 5 million to over 100 million. In 1965, the advent of Medicare and Medicaid provided a rocket-like increase in coverage bringing millions more into the safety net. The explosion of knowledge, research, technological advances, and massive hospital construction contributed to the revolution of the golden era.

Tragically, every revolution carries within itself the seeds of its own destruction. The golden era began unraveling as the rapidly rising costs were out of control and desperately needed containment. The cure for this, as we are now seeing, is producing another revolution which is shaking the entire health industry. The industry itself may be in danger as the revolution's excessive pursuit of cost is destroying the main gains of the past 40 years as it totally ignores the access to and quality of care, as well as humanism.

The thrust towards an egalitarian society has weakened and the sick, poor, and elderly suffer. Government funding is reduced, insurance, including Medicare, has either raised premiums or at least not lowered them, and their benefits are curtailed. Deductibles are added, rigid restrictions of hospital usage and length of stay are enforced. The demands for more outpatient services and less inpatient are there, and at times the control of modalities of treatment tend to ignore compassion and humanism. Large corporations are taking over much control of medicine and can manipulate the markets, their goal-profits. The rise of health care delivery systems often is profitable for the entrepreneur but too often ignore the quality and access to care aspects.

The result of this is the rise, by millions, in the number of uninsureds. The elderly are often pushed out of hospitals before they have recovered. The infant mortality rate has ceased its sharp descent and in some states is rising. Some reports show a rise in childhood preventable diseases.

Although documentation is sparse there is definite evidence of many falling through the gaping holes in the safety net. Some who complain about this are just trying to vilify the present administration, however, much of the concern comes from those who genuinely care about the sick, poor and elderly. The medical profession must continue to be counted with the latter in spite of the government, plaintiff attorneys, insurance companies and employers looking over our shoulder deciding how and how much to treat the sick. Our dreams of an egalitarian medical society must not dissolve as completely as Parsons' dreams.

Francis D. Donahue, M.D., President

Welcome New Members

Donald A. Prescher, M.D. (reinstated)
5404 Ames Ave.
Omaha, NE 68104

James D. Quinn, M.D. (reinstated)
310 Regency Pkwy.
Omaha, NE 68114

Zdenek A. Tusek, M.D.
1500 Koenigstein Ave.
Norfolk, NE 68701

Pradip K. Mistry, M.D.
109 No. 29th
Norfolk, NE 68701

In Memoriam

N. R. Miller, M.D. - (Born 1905 - died August 15, 1985) - Medical Specialty - General Practice. Doctor Miller was a graduate of the University of Nebraska College of Medicine in 1932 and practiced in Lincoln until his retirement. He was a member of the Nebraska Medical Association and the American Medical Association. Doctor Miller is survived by his wife, Rachel; a daughter, Mrs. Tracy (Barbara) Donovan of Lincoln; two brothers, Dr. Harold Miller of Estes Park, CO, and Addison P. Miller of Leavenworth, KS; a niece, Mrs. A. G. (Jackie) Paulson of Jacksonville, FL; and two grandchildren.

Richard D. Johnson, M.D. - (Born March 29, 1924 - died August, 1985) Medical Specialty - General Practice. Doctor Johnson was a graduate of the University of Nebraska College of Medicine in 1950 and practiced in Kearney until his retirement. He was a member of the Nebraska Medical Association and the American Medical Association.

R. F. Brendel, M.D. - (Born July, 30, 1915 - died August 12, 1985) Medical Specialty - General Practice. Doctor Brendel was a graduate of the University of Nebraska College of Medicine in 1942 and practiced in Plattsmouth until his retirement. He was a member of the Nebraska Medical Association and the American Medical Association. Survivors include his wife, Juanita; sons, Richard F. II of Omaha and Scott G. of Holdrege, NE; daughter, Gayle Lichti of North Platte; and five grandchildren.

A. B. Anderson, M.D. - (Born April 9, 1895 - died September 2, 1985) — Medical Specialty — General Practice. Doctor Anderson was a graduate of the University of Nebraska College of Medicine in 1921 and practiced in Pawnee City. He was a member of the Nebraska Medical Association and the American Medical Association.

C. T. Mason, M.D. — (Born April 25, 1908 - died August 18, 1985) — Medical Specialty — General Practice. Doctor Mason was a graduate of the University of Nebraska College of Medicine in 1932 and practiced in Superior until his retirement. He was a member of the Nebraska Medical Association and the American Medical Association. Survivors include his wife, Louis; two sons, Richard of Omaha and Thomas, Superior, one daughter, Mrs. Gerald Hurtz (Margaret), Omaha, 10 grandchildren; and three great grandchildren.

The Auxiliary

Resolution: 3
(A-85)

American Medical Association Auxiliary House of Delegates

Introduced by: Nebraska Medical Association Auxiliary
Subject: Education on Early Detection of Colorectal Cancer
Referred to: Reference Committee B

Whereas, Colorectal cancer is second only to lung cancer, with an incidence of 130,000 expected this year; and

Whereas, The cure rate for colorectal cancer is very high with early detection; therefore be it

RESOLVED, That the AMA Auxiliary encourage its state and county auxiliaries to support programs to educate the public about the importance of early detection; and be it further

RESOLVED, That these programs be undertaken with the approval of and in cooperation with the corresponding state and county medical societies/associations.

PRESIDENT'S MESSAGE

The two persons pictured with me are the reason this resolution was introduced from NMAA. They are two GOOD REASONS for each of you to consider doing something about Education on Early Detection of Colorectal Cancer in your area. Our nearly 800 members in Nebraska combined with the 80,000 total of the AMA Auxiliary could make quite an impact. We must lead so others will follow.

By Ardis Grace

(American Cancer Society Photo, by Bill Dean)

Coming Meetings

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

UNIVERSITY OF NEBRASKA COLLEGE OF NURSING, Lincoln & Omaha Divisions in cooperation with the Center for Continuing Education, University of Nebraska Medical Center — AIDS: The Current, Picture, Wednesday, November 13, 1985. Location: Center for Continuing Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha from 8:00 a.m. - 11:40 a.m. and at the Great Plains Room, East Campus Union, University of Nebraska, Lincoln from 12:30 p.m. - 4:10 p.m. Objective: To describe AIDS, including magnitude, clinical and research implications and considerations for health planning. Registration Fee: $10, $5 for students. Contact: Bevely J. Hays, RN, MS, Center for Continuing Education, University of Nebraska Medical Center. Phone (402) 559-4152.

UNIVERSITY OF NEBRASKA MEDICAL CENTER UPCOMING CONTINUING MEDICAL EDUCATION COURSES

February 17-22, 1986, Strategies in Oncology/Hematology for the Family Practitioner, Saddlebrook Resort, Tampa Florida.

February 26-March 5, 1986, Review and Update: General Prediatrics & Family Practice, Sheraton Royal Waikoloa, Kailua, Kona, Hawaii.

March 5-12, 1986, Review and Update: General Pediatrics & Family Practice, Royal Lahaina, Kaanapali Beach, Maui, Hawaii.

March 2-7, 1986, 6th Annual Keystone Medical Ski Conference "Diagnostic Dilemmas - The Approach and the Answers", Keystone Lodge, Keystone, Colorado. This course is held in conjunction with the Dental Ski Conference and the Nursing Ski Conference.

April 14-25, 1986, Family Practice Revew.

May 5-16, 1986, Family Practice Review.

June 29-July 3, 1986, Update on General Pediatrics, Jackson Hole, Wyoming.

June 7-10, 1986, Sports Medicine Update, Jackson Hole, Wyoming.

July 23-26, 1986, Lake Okoboji Sports Medicine Conference, Lake Okoboji, Iowa.

For further information, contact Marge Adey, University of Nebraska Medical Center, Center for Continuing Education, 42nd & Dewey Avenue, Omaha, Nebraska 68105. Phone (402) 559-4152.

32ND ANNUAL SCIENTIFIC MEETING — NEBRASKA OB-GYN SOCIETY — December 5, 6, & 7, 1985, MGM Grand Hotel, Las Vegas, Nevada. 9 hours credit. Registration fee $200. Contact: Dennis Beaver, M.D., 720 N. 87th Street, Omaha, Nebraska 68114 (402) 390-1200.

CREIGHTON UNIVERSITY

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

THIRD ANNUAL REVIEW & UPDATE — GENERAL PEDIATRICS AND FAMILY

PRACTICE — March 5-12, 1986 at the Royal Lahaina Hotel, Maui, Hawaii. Sponsored by the University of Nebraska Medical Center and the Creighton University School of Medicine. Credit: 20 hours AMA Category I. Topics include: infectious diseases, adolescent medicine, allergies, rheumatology, and pediatric cardiology. Fee: $400, physicians and $250, residents/interns. Contact: Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, Nebraska 68105, Phone: (402) 559-4152 or Hattie DeLapp, Creighton University School of Medicine, Phone: 1-800 228-7212, ext. 2550.

UNIVERSITY OF KANSAS

For information concerning the following continuing education programs sponsored by the University of Kansas Medical Center contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103, (913) 588-4480.

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE — September 25-26, 1985, November 6-8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. Credit: 13.5 hrs. AMA Category I, 13.5 hrs. AAFP. Maximum enrollment: 24 persons per session.

ADVANCED CARDIAC LIFE SUPPORT INSTRUCTOR COURSE — November 8, 1985. Sponsor: University of Kansas Medical Center. Location: University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SCHEDULED MEETINGS

CLINICAL UPDATE I — November 2, 1985. For Southeast Nebraska's M.D.'s and Physicians Assistants. Sponsors: Lincoln Medical Center Association and Lancaster County Medical Society. This is a continuing medical education program designed to address and update the care of patient health care problems presenting in primary care M.D. offices on a day-to-day basis. Approved for 8 credit hours of AMA Category I credit and 8 hours of AAFP credit. Location: Nebraska Center for Continuing Education, Lincoln, Nebraska, 33rd and Holdrege St. Lodging available evenings of November 1 and 2. Reservations will be needed. There is a dinner being planned for the evening of November 2, spouses welcome. Contact: P. D. Duensing, Ed.D., Executive Secretary, Lancaster County Medical Society, (402) 474-2405.

3RD ANNUAL CHRONICALLY ILL AND AGING CONFERENCE — November 21-23, 1985, Oklahoma City, Oklahoma. CME Credits given. For information contact: Dr. John A. Mohr (III), VAMC, 921 NE 13th, Oklahoma City, OK 73104 or call 405-270-5149). (PLEASE NOTE THIS IS THE WEEKEND OF THE OKLAHOMA UNIVERSITY - NEBRASKA GAME AT OKLAHOMA CITY, OKLAHOMA!)

THE NEBRASKA CHAPTER OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS will hold their 38th Annual Scientific Assembly, April 11 and 12, 1986 at the Marriott Hotel, Omaha, Nebraska. Contact: Phyllis Hansen, Executive Director, Nebraska Academy of Family Physicians, 401 No. 117th, Suite 202, Omaha, Nebraska 68154 (402) 333-5856.

Picture Gallery

1985 Nebraska Medical Association Fall Session

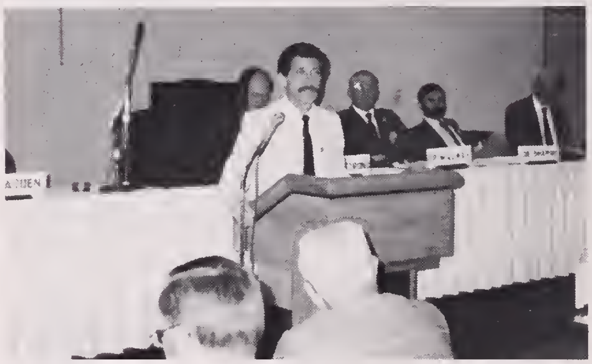
Board of Councilors meeting

Board of Councilors meeting

Doctor Harry W. McFadden presiding at House of Delegates meeting

Doctor Francis D. Donahue addressing the House of Delegates

Doctor Gregg F. Wright addressing the House of Delegates



Doctor Robert H. Waldman addressing the House of Delegates

House of Delegates meeting

House of Delegates meeting

Doctor Ronald Klutman and Doctor Francis D. Donahue

House of Delegates Reference Committee in Session

House of Delegates Reference Committee in Session

House of Delegates Reference Committee in Session

House of Delegates Reference Committee in Session

House of Delegates Reference Committee in Session

Doctor Perry T. Williams presenting reference committee report

Doctor Gordon D. Adams presenting reference committee report

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AMA News Notes

(Continued from page 14A)

the difficulties between the societies and the PROs mirrored the difficulties described in physicians' letters to the AMA monitoring project. Physicians who wish to contibute further information may write to the PRO Monitoring Project, P.O. Box 10947, Chicago, Ill. 60610.

* * *

Relative Value Scale for physicians' services will be developed by Harvard U. under a contract with the Health Care Financing Administration. The contract was scheduled to become effective Sept. 15. The AMA will be a subcontractor under the proposal. The Association will provide advice on the project's overall objectives, directions, and research methodology. With the cooperation of national medical specialty societies, it will recruit physicians to be involved in the study. The Association also will analyze and tabulate physicians' practice costs. HCFA's interest in the project stems from a desire to determine whether fee schedules based on an RVS might provide a workable method for reimbursing physicians under Medicare. 'The AMA is pleased to have a key role in the development of this RVS,' said AMA Executive Vice President James H. Sammons, M.D. 'This represents a real opportunity for all physicians to be in a leadership role on the reimbursement issue.' The project is expected to run for 30 months.

* * *

Third-Party Payment constitutes a significant part of physicians' revenues, the AMA Socioeconomic Monitoring System of the Center for Health Policy Research reported. Medicare and Blue Cross/Blue Shield accounted for 22.7% and 21.2%, respectively, of physician incomes. Other third-party payers' contributions to physicians' incomes: Medicaid (9.3%), health maintenance organizations or individual practice associations (6.1%), and private insurance companies (20.5%). The SMS core survey of 4,040 non-federal patient care physicians found that hospital-based specialists, including anesthesiologists, pathologists, and radiologists, derived the largest percentage of their income from Medicare (30%) and Blue Cross/Blue Shield (26.9%). Surgical specialists had the largest percentage of income from private insurance (24.7%). Medical specialists had the largest percentage of income from Medicaid (11.2%) and HMOs/IPAs (7.3%).

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of $10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1512 First National Bank Building, Lincoln, Nebraska 68508.

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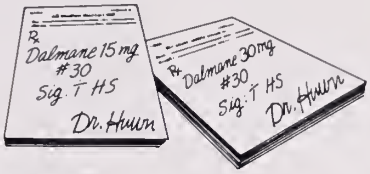

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported headache, heartburn, upset stomach, nausea, vomiting diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e g* excitement, stimulation and hyperactivity

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VOL. 70, NO. 12 DECEMBER 1985

THE NEBRASKA MEDICAL JOURNAL

Nebraska Medical Association
Organized 1868
Incorporated 1919

117
Years

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The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly

Information for Patients: Headache may occur during initial therapy with SORBITRATE Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent Cutaneous vasodilation with flushing may occur Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose Drug rash and/or exfoliative dermatitis may occasionally occur Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended The extent to which development of tolerance should modify the dosage program has not been defined *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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Review articles will be considered, and should generally be limited to less than 4,000 words and approximately 30 references.

Manuscripts describing original clinical or laboratory research should be limited to 2,000 words and approximately 20 references.

Acknowledgements must be given when material from other publications is included. Provide names of authors, title of article, title of journal or book, volume number, pages, month and year, and publisher's permission to reprint.

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AMA News Notes

Physician Demand for the universal claim form, which the AMA developed in 1974, is likely to increase. The Health Care Financing Administration has published two rules in the **Federal Register** that require physicians to purchase the AMA Health Insurance Claim Form for filing Medicare and Medicaid claims. A cost-saving measure published Sept. 30 directed Medicare carriers to stop distributing the HCFA-1500 form free to physicians, effective Oct. 30. Previously, the government supplied the forms to Medicare carriers in half the states and local jurisdictions. The carriers, in turn, made them available to physicians. Under the new regulations, all providers will be required to purchase the AMA Health Insurance Claim Form in single sheets or continuous-feed format. The AMA will be a major supplier. In another new regulation issued Oct. 7, HCFA directed state Medicaid management information systems to use the Health Insur-

(Continued on page 13A)

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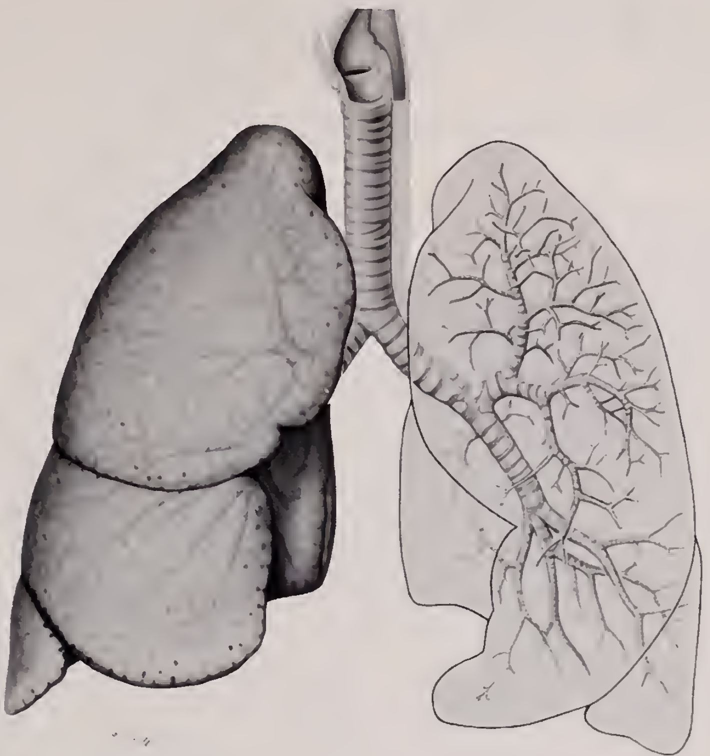

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

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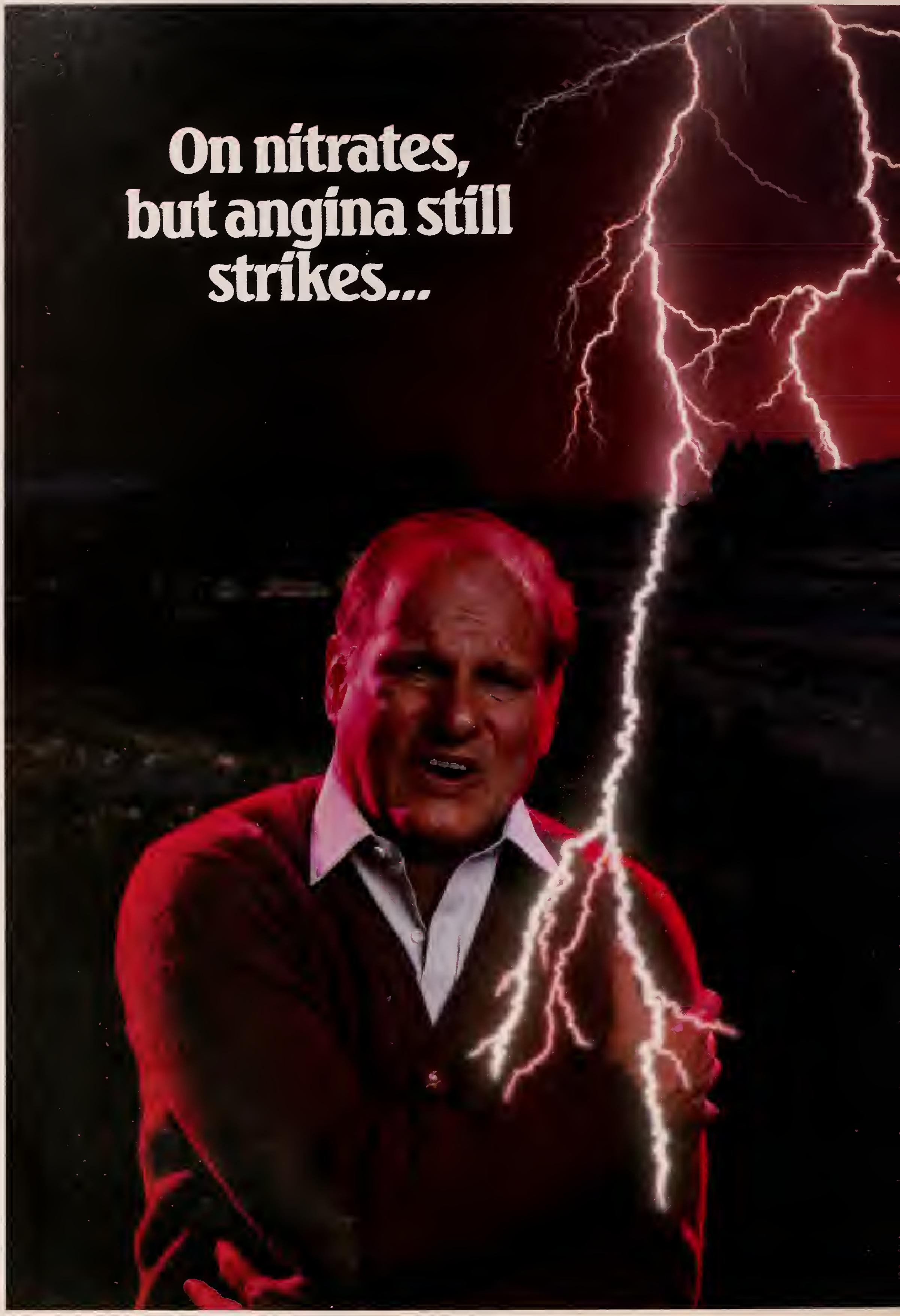
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. 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One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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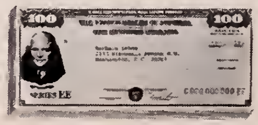

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THE NEBRASKA MEDICAL JOURNAL

Reference to Editorial Regarding Preadmission Certification

ROGER D. MASON, M.D.
Senior Vice President and Medical Director
Blue Cross and Blue Shield of Nebraska

I have read the editorial in the October issue of **The Nebraska Medical Journal** on precertification and want to point out significant errors and misconceptions contained in this editorial.

First, preadmission certification is not aimed at limiting access to health care, rather it defines in advance what care is payable under an insurance contract and communicates that information to the patient, the physician, and the hospital involved in the care of the individual. Whether the program is administered by insurance companies, employers, governmental units, third party administrators, or others, this is the goal of preadmission certification. In addition, Blue Cross and Blue Shield of Nebraska is providing additional information which can and should be used to identify other contractual limitations to increase the flexibility of the coverage and maximize the benefits to the patient in the most cost-effective manner possible within the constraints of the contract.

The editorial also states in part that "This person will then decide if hospitalization is indeed needed . . . ". This is simply not true. The program administered by Blue Cross and Blue Shield of Nebraska, as well as **all** the other programs I am aware of, only determine the contractual benefits payable under the contract of coverage. We at Blue Cross and Blue Shield are perfectly willing to leave the determination of the patient's need for services, as well as the quality of that service in the realm of the medical profession. What is paramount here is that the physician should determine the need for services and the entity responsible for financing that service should determine if that care falls within the scope of coverage of the particular contract involved on a **prospective** basis so there will be no **retroactive** surprises for the patient. We have been particularly careful to state this clearly and concisely at each of the meetings we recently held across Nebraska, and you will also find this stated in the literature distributed about this program.

The fourth paragraph of the editorial begins with "When insurance companies assume the management of a sick person's care, . . . ". This is another incorrect assumption and is subject to the same clarification I have given above. Entities using precertification are interested in the **financing** of care, not the **delivery of that care.** Physicians and non-physicians alike are concerned with cost-effectiveness and getting the most care for the most people possible. While non-physicians have no expertise in determining the best way to meet the patient's needs, there are many who do have expertise in how to finance that care. I believe it will take the best efforts of all of us to maintain quality care and make costs affordable. We must work together to reach that end.

Blue Cross and Blue Shield of Nebraska is very willing to discuss any of these issues with the members of the Nebraska Medical Association at any time convenient to them. I am sure we could learn many things from each other that would improve the effectiveness of these programs while minimizing the conflicts.

Whipple Procedure

IT is a real pleasure to be asked to write an editorial on the "Whipple Procedure" as Dr. A. O. Whipple was one of the finest professors and advisors that I have known.

Carcinoma of the pancreas is on the increase throughout the world. It is now the fourth most common cause of death due to carcinoma following lung, breast, and colorectal carcinomas. Approximately 20,000 deaths due to cancer of the pancreas occur in the United States annually. As with all carcinomas, the problems are two-fold; first, diagnosis; and second, treatment.

Because of the non-specific symptomatology and the anatomical location of the pancreas, diagnosis is frequently late. The newer diagnostic procedures of computerized tomography, ultrasonography, retrograde endoscopic cholangiopancreatograms, fine needle aspiration, and angiography have all recently contributed to the earlier diagnosis but none have solved the problem. Serum markers, to date, have been non-specific and of little value but are badly needed.

Treatment of pancreatic carcinoma consists of surgery, radiation, and chemotherapy. Recent advances in radiation show some promise as do combined chemotherapeutic regimes. Neither are effective for cure at the present time. Surgical treatment of carcinoma of the pancreas has, in the past, yielded dismal results, with cures being extremely rare and with mortality being high.

The present paper demonstration that surgical treatment can be carried out by experienced surgeons in ideal situations with much attention to detail technically in the pre-operative period, in the operative period, and in the post-operative period. The choice of operation for ductal adenocarcinoma of the pancreas is not clear, but pancreaticoduodenectomy should be performed for selected patients by skilled surgeons and not categorically denied to all patients. It is not a procedure to be performed by a surgeon who infrequently faces this problem.

DWIGHT CHERRY, M.D.

ORIGINAL ARTICLES

Experience With Pancreaticoduodenectomy (Whipple Procedure) at University Nebraska Hospital

PATRICK R. GREER, M.D.
JON S. THOMPSON, M.D.*
PAUL E. HODGSON, M.D.
From the Department of Surgery, University of Nebraska Medical Center

WHIPPLE first described pancreaticoduodenectomy for lesions involving the head of the pancreas in 1935. However, the procedure continues to undergo technical modifications, and the indications for its use remain controversial because the morbidity and mortality of the procedure can be substantial.[1-4] The Whipple procedure is considered the operation of choice in most centers for resectable carcinoma of the head of the pancreas, periampullary region and duodenum as well as selected patients with pancreatitis and pancreatic trauma.[1,2] Recent modifications include preservation of the pylorus and total pancreatectomy during pancreaticoduodenectomy. This report reviews the surgical experience with 20 pancreaticoduodenectomies in a single institution over an 8 year period to evaluate its current use.

Materials And Methods

We reviewed the charts of 20 patients undergoing pancreaticoduodenectomy at the University of Nebraska Medical Center between 1976 and 1984. There were 9 females and 11 males ranging from 27 to 77 years with a mean of 64 years. Clinical and laboratory data as well as operative methods, morbidity and mortality were determined from the medical records. Surgical residents participated in the operations under the direct supervision of four attending physicians.

Reconstruction was generally accomplished by end-to-side anastomosis of the common bile duct and pancreatic duct to the jejunum proximal to the gastroenterostomy. In one patient the pancreatic jejunostomy was an end-to-end anastomosis. In 2 patients the pancreatic duct was so small that it was ligated. Stents were routinely used in the patients with pancreaticojejunostomy. Two methods of placing jejunostomy feeding tubes were used. Either a rubber catheter was inserted into the end of the jejunal limb proximal to the biliary and pancreatic anastomoses or needle catheter jejunostomy was performed as described previously.[3] Pyloric preservation was accomplished by dividing the duodenum 1cm distal to the pylorus taking care to preserve the blood supply along the lesser curve to the stomach and duodenum, and preserving the nerves of Latarjet.[4] The anastomosis was then completed using the end of the duodenum sutured to the side of the jejunum distal to the pancreatic and biliary anastomoses.

Results

Twenty patients underwent pancreaticoduodenectomy. Sixteen (80%) patients underwent operation for malignant disease and four for benign conditions. The indications for operation are listed in Table I.

Fifteen (75%) patients presented with abdominal pain and weight loss. Only three (15%) patients had evidence of gastrointestinal obstruction prior to operation. Jaundice was present preoperatively in 8 (40%) patients and the serum bilirubin was greater than 10 mg% in 2 patients. Alkaline phosphatase was elevated in 14 (70%) patients preoperatively. Computerized tomography was performed in 9 patients with cancer and was abnormal in

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TABLE I
Postoperative Diagnosis

Adenocarcinoma of Pancreas	7
Ampullary Carcinoma	5
Carcinoma of Duodenum	3
Cystadenoma	1
Islet Cell Tumor	1
Pancreatitis	2
Angiodysplasia	1
Total	20

every case in which it was used (pancreatic mass or ductal dilatation). Ultrasonography was used in 9 patients and demonstrated either ductal dilatation or a mass in all patients with cancer except one. Endoscopic retrograde cholangiopancreatography was performed in 10 patients and in each case either ductal obstruction or displacement or a mass was noted. Percutaneous transhepatic cholangiography (ERCP) was performed in only four patients but was abnormal in every instance. The catheters were not left in place for preoperative biliary decompression. In patients with carcinoma the diagnosis was made preoperatively in 4 cases and confirmed intraoperatively in 9 patients. In only one patient was the diagnosis of cancer made in the postoperative specimen.

There were a total of fourteen postoperative complications occurring in 12 (60%) patients (Table II). Three (15%) patients required reoperation, two for postoperative abscess and one for a pancreatic leak. Pancreatic leak was not a cause of death in any of these patients. One patient with a needle catheter jejunostomy developed a catheter leak resulting in cellulitis and cessation of its use for feeding. Postoperative hospital stay ranged from 11 to 86 days with an average of 31.6 days. There were no perioperative deaths in this series.

TABLE II
Postoperative Complications

Pancreatic Leak	3
Pulmonary	3
Delayed Gastric Emptying	3
Abscess	2
Cardiac	1
Gastrojejunostomy Leak	1
Leak From Needle Cath. Jejunostomy	1
Total	14
Postoperative Deaths	0

Intraoperative blood loss averaged 1980 ml (range 580-6,000) and average operative time was 8 hours 50 minutes (range 6 hours 30 minutes to 15 hours).

The pylorus was preserved in 4 patients, including 2 with ampullary carcinoma, 1 with carcinoma of the pancreas and 1 with an islet cell tumor. This technique did not compromise the margin of resection in any case. Delayed gastric emptying was noted during the early post-operative period in 2 of the 4 patients undergoing pyloric preservation. However, none of these patients have postgastrectomy symptoms or persistent impaired gastric emptying.

Total pancreatectomy was performed in three patients, including 1 with carcinoma of the duodenum, 1 with pancreatitis with an abscess, and 1 with cystadenoma. One patient required insulin prior to operation. Only one patient not requiring insulin preoperatively required insulin therapy after the Whipple procedure.

Fourteen (70%) patients had evidence of malnutrition preoperatively. Fourteen patients gave a history of weight loss and 11 patients (55%) had preoperative serum albumin levels less than 3.5mg%. Six patients had absolute lymphocyte counts less than 1500 per mm.[3] A feeding jejunostomy was placed in 14 (74%) patients and used an average of 22 days with a range of 7 to 50 days. TPN was required in only three patients.

Six of the 14 patients available for follow-up are alive following operation for malignant disease. All 5 patients with periampullary carcinoma are still alive an average of 16.6 months after operation with a range of one to 29 months. All seven patients with carcinoma of the pancreas have died an average of 14.7 months after operation (range of 5 to 27 months).

Discussion

Pancreaticoduodenectomy is a technically demanding operation and the indications for the operation remain controversial. There are several important issues in the use of this procedure. The first is whether or not the operation can be performed with an acceptable morbidity and mortality. Another concern is the long term functional outcome after the operation and how this affects the patient's quality of life. The expected survival following operation for malignancy is also an important issue and should influence how widely the procedure is performed.

Although the operative mortality has often been substantial, several centers have now shown that the operation can be performed with a 5% mortality rate.[5,6,7,8] This has been our experience as well. Complications occur following the Whipple procedure in 20 to 80% of patients. Sepsis, hemorrhage, and anastomotic leaks, especially at the pancreaticojejunal anastomosis, appear to be the most lethal complications following pancreaticoduodenectomy.[9,10,11] Sixty percent of the patients in the present study had postoperative complications. Complications related to the pancreas occurred in 4 patients. Lerut et al[11] found that the urgency of operation, character of pancreatic tissue, serum bilirubin greater than 6 mg% and age greater than 65 were associated with an increased risk of pancreatic fistula. This may partially explain the low incidence of pancreatic fistulas in the present study. Only one patient in this study required reoperation for a pancreatic fistula while 2 required operation for an abscess. None of the postoperative complications lead to a fatality. Despite the known risks of pancreaticoduodenectomy, we feel that it can be performed with acceptable morbidity and mortality if patients are carefully selected and strict attention is paid to technical details.

Many retrospective studies have suggested that reduction of elevated bilirubin levels by percutaneous transhepatic biliary drainage would reduce the high morbidity and mortality associated with pancreaticoduodenectomy.[12-15] However, the only prospective study on this subject demonstrated no difference in the operative mortality between patients receiving percutaneous transhepatic biliary decompression and those not.[16] It is clear that preoperative percutaneous transhepatic biliary drainage is not an innocuous procedure.[12,15,16,17] This technique was a direct cause of two deaths due to catheter related infection in one study.[17] In addition preoperative biliary drainage stopped progressive weight loss in only 28% of patients and increased albumin in only 50% despite intensive nutritional support. We do not feel that preoperative percutaneous drainage is of sufficient benefit to warrant delaying operation and it was not used in the present study.

With the increasing use of ERCP and improved methods of intraoperative biopsy, the diagnosis of carcinoma should be made prior to resection in the vast majority of cases. In only 4 of 14 patients in this study was the diagnosis of carcinoma confirmed preoperatively while it was made intraoperatively in 9 patients. The Whipple procedure was performed only once for suspicion of carcinoma without a tissue diagnosis prior to resection and this was found to be an Islet cell tumor postoperatively. The frequency of preoperative diagnosis in this series is similar to that of Wise who was able to make a preoperative diagnosis in 26% of patients.[18]

We feel needle catheter jejunostomy is a useful adjunct in the management of patients following radical pancreaticoduodenectomy. The majority of our patients presented with evidence of malnutrition as indicated by weight loss in 70% and hypoalbuminemia in 55% of patients. The average postoperative hospital stay was 31.6 days and these patients often develop prolonged gastric atony postoperatively preventing oral intake for 7-10 days. Needle catheter jejunostomy may be used for feeding elemental diets within 24 hours of operation. Maintaining optimal nutritional support during this period of convalescence is critical in minimizing morbidity. The usefulness of this technique for postoperative nutritional support has been reported previously.[3] Because of the liberal use of needle catheter jejunostomy, total parenteral nutrition was required in only 3 patients. In the event an enteric fistula develops following Whipple procedure, needle catheter jejunostomy provides a safer and more economical method of nutritional support than TPN.

While the functional outcome of the Whipple procedure has generally been acceptable, recent technical modifications may improve these results further. Pyloric preservation has been proposed to prevent post gastrectomy disorders. This modification does not compromise the extent of resection in the majority of cases. Marginal ulceration was reported in only one of 28 patients in the study by Braasch et al[4] with a mean follow-up of 24 months. One other patient had evidence of a jejunal ulcer on x-ray that could not be found on endoscopy.

The incidence of marginal ulcers is significant after standard pancreaticoduodenectomy when adequate gastrectomy or vagotomy is not performed.[5,9,19,20] Scott et al[19] found that the incidence of marginal ulcer after pancreaticoduodenectomy without vagotomy was 36% compared to zero when vagotomy was performed. Normal gastric acid output should occur following pyloric preservation since the antrum and vagal function are preserved. Only longer follow-up will determine if marginal ulceration will pose a problem following pyloric preservation. Transient impaired gastric emptying appears to be the main disadvantage of this technique and this has been previously demonstrated.[4,7] Braasch feels the most likely etiology of this is the marginal blood supply remaining for the pylorus.[4] It is also possible that manipulation of the stomach results in a neuropraxia of the nerves of Laterjet. Although two of the four patients in the present study undergoing pyloric sparing procedures had delayed gastric emptying in the early postoperative period, this resolved within a few weeks. Warshaw has advocated performing a gastrostomy at the time of operation when the pylorus is preserved.[7] Our patients have not experienced any postgastrectomy symptoms, such as dumping or diarrhea, when the pylorus has been spared but followup is short. Two patients undergoing gastric resection have had late complications, including delayed gastric emptying in one patient and marginal ulceration in another.

The first long term survivor of a total pancreatectomy in 1944 demonstrated that pancreatic enzyme replacement could sustain life following removal of the entire pancreas.[21] By the early 1970s many authors proposed total pancreatectomy over the Whipple Procedure for carcinoma of the head of the pancreas based on several theoretical advantages.[22-24] The most important was elimination of the pancreatojejunal anastomosis but total pancreatic resection also results in a wider lymphadenectomy and irradication of multicentric disease. However, the Whipple Procedure is still generally preferred because the theoretical advantages of total pancreatectomy have not resulted in lower morbidity or improved survival.[5,25,26] In the Mayo Clinic Series the operative mortality for total and subtotal pancreatectomy (Whipple procedure) was 12% and 4%, respectively, while their corresponding 5-year survival rates were 2% and 4%.[5] Total pancreatectomy was used selectively in three patients in the present study, once each for patients with pancreatitis, carcinoma of the duodenum and cystadenoma. It was necessary in each instance to include the entire disease process in the resected specimen.

Long term survival following pancreaticoduodenectomy varies greatly depending on the disease being treated. Numerous studies have shown that the 5 year survival for ampullary carcinoma is 40%.[1,2,27] Resection is clearly appropriate in these patients. However, the 5 year survival for cancer of the pancreas is 5% and the indications for curative resection in this condition are more controversial.[1,2,28] Some surgeons feel that survival following pancreaticoduodenectomy is so rare and the morbidity and mortality of the procedure so high that resection is not justified.[29,30] However, it is often difficult to distinguish pancreatic from periampullary cancer prior to resection. In addition, curative resection offers the possibility of long term survival in such patients while other therapy does not. Pancreaticoduodenectomy should be performed infrequently for benign conditions because of the risk of the procedure and other therapeutic options. We feel that pancreaticoduodenectomy continues to remain the operation of choice for resectable carcinoma of the pancreas and periampullary carcinoma as well as selected benign conditions.

Summary

A retrospective chart review of 20 patients is presented. The postoperative complication rate was 60%, but no perioperative deaths occurred. Operative results are highly dependen on proper selection of patients and attention to nutritional support and technical details. Modifications of the operation have evolved to improve the long term functional results. Provided a reasonably low operative mortality can be achieved, we feel pancreaticoduodenectomy should remain the procedure of choice for resectable carcinoma of the head of the pancreas, periampullary carcinoma, selected benign conditions and trauma.

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Comparison of Colectomy for Benign and Malignant Disease

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WHILE there are numerous reports of the outcome of colectomy for a variety of conditions, there is little comparative data for benign and malignant diseases. Although the same operative procedure may be performed for either benign or malignant conditions, several factors might influence the outcome. Such factors include not only the condition requiring operation but the urgency of the procedure, preoperative bowel preparation, and the patient's age and general health. We reviewed our experience with patients undergoing colectomy to determine the outcome for patients with benign or malignant conditions and to identify factors influencing the outcome.

Materials and Methods

The records of 250 patients who underwent colectomy between 1973 and 1985 at the University of Nebraska Medical Center Hospitals were reviewed. The study group consisted of patients with primary diseases or injury of the colon. Patients with colonic involvement from other malignancies were excluded. There were 99 patients who underwent colectomy for malignancy while 151 patients were operated on for benign disease.

The preoperative preparation, indications for operation, procedure employed, length of postoperative stay and postoperative complications were determined. Resection of unprepared intestine for obstruction, perforation, gangrene or bleeding was considered emergent colectomy. Elective colectomy implies the intestine was mechanically prepared and the patient stabilized for operation. Septic related morbidity and mortality was defined as that due to intraabdominal sepsis, systemic sepsis or pneumonia. Operative mortality was defined as death from any cause within 30 days of the operation or anytime thereafter if the patient remained in the hospital for complications related to the operation.

An uncorrected chi square test was used for statistical comparisons of the two groups with $p < .05$ for significance levels.

Results

Ninety-nine of the 250 (39.6%) colectomies performed at our institution were for malignancy while 151 (60.4%) were for benign disease. Diverticular disease was the most frequent diagnosis in the benign group, followed by inflammatory bowel disease and polypoid conditions, as shown in Table I. Dukes staging was clearly identified in 76 of the malignant cases and showed that 12 tumors (16%) were Stage A, 28 (37%) Stage B, 22 (29%) Stage C and 14 (18%) were metastatic (Stage D).

TABLE I
Diseases Requiring Colectomy

Diagnosis	# of Patients	% of Total Series
Colorectal Malignancy	99	39.6
Benign Disease	151	60.4
Diverticular Disease	44	29.1
Inflammatory Bowel Disease	34	22.5
Polypoid Conditions	20	13.2
Angiodysplasia	7	4.6
Spontaneous Perforation	7	4.6
Miscellaneous	39	25.8

The overall morbidity and mortality for the 250 patients were 25.2% and 6%, respectively. Table II demonstrates the differences in morbidity and mortality between the two groups with respect to emergent versus elective operations. The morbidity and mortality for elective colectomy was similar in both benign and malignant groups. Emergent operations were performed in 41 (27%) of the 151 patients with benign disease as compared to

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TABLE II

Complications and Urgency of Operation

	Benign			**Malignant**		
	Elective	**Emerg.**	**Total**	**Elective**	**Emerg.**	**Total**
Operation	110 (73%)	41 (27%)	151	92 (93%)	7 (7%)	99
Morbidity %	19.1	36.6	23.8	27.2	28.6	27.3
Mortality %	2.7	22.0	7.9	3.3	0.0	3.0

7% of the patients with malignancy ($p < .005$). The morbidity and mortality of emergency colectomy was significantly greater than that of elective operations ($p < .05$) in the benign group. The average postoperative hospital stay was 20 days in the benign group and 16.6 days in the malignant group.

Septic related complications accounted for 66% of the morbidity following emergent operations and 43% following elective resections in the benign group. Eight of nine deaths following emergent colectomy were related to sepsis in this group. In contrast, all of the complications following emergent colectomy and 8% of complications after elective resection were related to sepsis in the malignant group. Pulmonary complications were most common in the malignant group, consisting of 4 patients with pleural effusions, 2 with pulmonary embolus and 1 with postoperative pneumonia. The three deaths which occurred in the malignant group were caused by myocardial infarction, pneumonia, and multiple organ failure.

Overall, an ostomy was created in 103 (41%) patients. Seventy-eight (52%) were performed in the benign group with 83% of emergent operations including ostomy and 40% of elective operations. In the malignant group a stoma was formed in only 25% of the patients ($p < .005$). Colostomy was the most common stoma in the benign group (49%), followed by ileostomy (42%), Koch continent ileostomy (4%) and jejunostomy (4%). All of the stomas formed in the malignant group were colostomies.

The operations employed most commonly in both groups were sigmoid colectomy and right hemicolectomy. Total colectomy was performed more frequently for benign conditions. ($p < .005$) (Table III). The most frequent indications for operation in the benign group were perforation, bleeding, malignant potential and fistula.

The age of patients in the benign group ranged from 14 to 80 years with an average age of 51. Only 14% of the patients were greater than 70 years of age. This contrasted to the malignant group where the average age was 68 years and 49% of the patients were greater than 70 years of age ($p < .05$).

Discussion

The majority of patients undergoing colectomy at our institution have a benign condition (60%). This is greater than the 38-47% reported by others[1,2] and most likely reflects different referral patterns. In the present study diverticular disease (29%), inflammatory bowel disease (22%), and polypoid conditions (13%) were the most common benign conditions requiring an operation, which is similar to other studies.[1,2] The overall mortality rate of 6% and morbidity of 25% in this study is also consistent with other reports.[1-4] There are several differences between colectomy for benign and malignant disease that can influence the outcome following operation.

Benign conditions more frequently require emergent colectomy. Watne et al[4] found that 35% of patients with diverticular disease required an emergent procedure compared to 3% of patients with cancer. Irvin[3] reported that 64% of emergent colectomies are performed for benign conditions. In the present study 27% of patients with benign disease required emergent colectomy compared to 7% in the malignant group. The greater morbidity and mortality of emergent colectomy is well recognized.[3,5] The unfavorable outcome in emergent

TABLE III

Operations Performed

Operative Procedure	**# Patients**		**% Total Series**
	Benign	**Malig.**	
Sigmoid Resection	56	34	36.0
Right Hemicolectomy	26	29	22.0
Subtotal Colectomy	31	10	16.4
Total Colectomy	20	0	8.0
Left Hemicolectomy	14	13	10.8
AP Resection	0	11	4.4
Transverse Colectomy	4	2	2.4

colectomy is thought to arise from operating an unprepared bowel and concomitant perforation or abscess. This is supported by the high rate of septic related complications in the benign group.

Patients undergoing colectomy for benign disease appear to be younger than those requiring operation for malignancy. Only 14% of the patients in the present study were greater than 70 years of age compared to those with malignant conditions in whom 49% of the patients were greater than 70 years of age. Several reports have documented the increased morbidity and mortality rates associate with advanced age of the patient.[3,4,6] The morbidity and mortality in the malignant group was not greater than that in the benign group, which suggests that other factors were more important in determining the patient's outcome than the age of the patients.

The colonic disease requiring resection should also influence the outcome. The high frequency of complications following resection for diverticular disease and inflammatory bowel disease are well recognized.[7,8] Bokey et al[9] found that the complication rate in patients undergoining elective sigmoid resection was greater for diverticular compared to malignant disease. Diverticular and inflammatory bowel disease may entail a more difficult dissection because of inflammation of surrounding tissue. In addition, more extensive operations are often required in these patients because of more diffuse colonic involvement. In the present study, total and subtotal colectomy were required more frequently for benign conditions than for malignant disease.

The increased frequency of ostomy formation in benign conditions has been previously described. Mirelman et al[10] found that 64% of patients requiring colostomy had a benign disease. Similarly, Bokey et al[9] found that ostomies were required in 36% of patients undergoing operation for benign disease versus 5% in patients with malignancy. In the present study, ostomy formation was also much more frequent in the benign group (52% versus 25%). This reflects the increased number of emergency operations but even in the elective benign colectomies, ostomies were formed in 40% of patients. The increased instance of ostomy formation is most likely a reflection of the underlying inflammation, infection, and perforation seen with benign conditions. Ostomy complications occurred in only 6% of patients which compares favorably with 21% reported by Mirelman et al.[10]

Summary

60% of 250 patients undergoing colectomy at our institution have a benign condition. Patients undergoing colectomy for benign disease more frequently require emergency colectomy with an attendant greater morbidity and mortality. The overall mortality rate in the benign group was 7.9% compared with 3.0% in the malignant group. The majority of complications in the benign group are septic related and reflect the underlying disease process. Stoma formation and total colectomy were utilized more frequently in patients with benign disease reflecting the diffuse and complicated nature of these conditions. Operation for non-malignant conditions should not be considered a benign procedure.

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Adenocarcinoma Arising In Barrett's Esophagus

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BARRETT'S esophagus refers to the presence of columnar epithelium in the esophagus instead of the usual stratified squamous epithelium. There are two theories regarding its pathogenesis — congenital and acquired. [1,2]

The congenital theory is based on the fact that when the esophagus first develops from the foregut, it is lined with columnar epithelium which is gradually replaced by squamous epithelium during the fifth and sixth fetal months. Objections to this theory are that Barrett's esophagus has not been described in a fetus although there is a report of a case in a neonate,[3] and the embryonic esophageal epithelium does not contain intestinal-type goblet cells as does Barrett's epithelium.[4,5]

The acquired theory is more generally accepted.[6,7,8] Since nearly all patients with Barrett's esophagus are middle-aged and have gastroesophageal reflux, it is assumed that the destruction of the squamous epithelium from chronic esophagitis results in its replacement by an inherently more acid resistant columnar epithelium. No one understands why this occurs in some patients with gastroesophageal reflux and not in others. In one study, 140 of 1225 patients (11%) with reflux esophagitis were found to have Barrett's esophagus.[9]

The incidence of adenocarcinoma in Barrett's esophagus is 10%.[10] A review of the English literature revealed 121 cases of adenocarcinoma associated with Barrett's esophagus in which gastric adenocarcinoma invading the esophagus could be excluded.[11]

We will report two new cases of adenocarcinoma arising in Barrett's esophagus and make recommendations for management.

Case Reports

Case #1: R.P., a 55 year old man, was asymptomatic until he noticed a large black stool 12/1/83. Since he was known to drink at least 10 beers daily, his physician felt he could have esophageal varices. A barium swallow showed defects in the distal ⅓ of the esophagus compatible with varices, so esophagoscopy was done. This revealed multiple submucous masses beginning at the mid-portion of the thoracic esophagus. Multiple biopsies were done and adenocarcinoma was found. He smoked 2 packs of cigarettes daily and had a 30 year history of exposure to asbestos, being employed as an insulator. A sister had lung cancer and a brother had laryngeal cancer. Liver function tests were normal.

On 12/9/83 his distal esophagus was resected from above the junction of the middle and lower third with a right colon interposition. The specimen revealed a moderately well-differentiated adenocarcinoma with spread to two of six nodes. Gastric type mucosa was present from the esophago-gastric junction to the upper end of the resection.

He was dismissed from the hospital about 4 weeks after his operation.

Case #2: R.T., a 56 year old man, entered the hospital complaining of substernal burning pain for 6 weeks associated with dysphagia and weight loss. He had been on Mylanta and Alternagel for his hiatus hernia. He admitted drinking a 6 pack of beer daily for years and was a heavy smoker. Esophagoscopy revealed a sliding hiatus hernia with inflammation of the distal esophagus and a tumor in the distal ⅓ of the esophagus. Biopsies revealed a poorly differentiated carcinoma, probably squamous cell.

On 2/20/84 he underwent esophagectomy

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from the junction of the upper and middle third of the thoracic esophagus with a right colon interposition. At that time, two large polyps were found in the cecum and transverse colon and were removed. Pathologically, he was found to have adenosquamous carcinoma in Barrett's esophagus with metastases to two nodes and two villous adenomas of the colon.

He also was dismissed from the hospital about 4 weeks after his operation.

Discussion

The average age of patients with adenocarcinoma of the esophagus is 57 years. The male-to-female ratio is 5.5:1. Seventy one percent had a hiatal hernia, although 36% of the patients had no history of reflux.[11]

The symptoms and signs reported in adenocarcinoma in Barrett's esophagus have been heartburn, regurgitation, dysphagia, bleeding (with hematemesis, melena, or anemia), odynophagia, weight loss, fatigue, vomiting, cough, and scleroderma.[12]

The X-ray characteristics have included stricture, polypoidulcerative mass, varicoid appearance, and a polyp.[12]

Barrett's esophagus is easily recognized at endoscopy by a sharp demarcation between the pale squamous mucosa and the salmon-pink columnar mucosa.[11,13] Instillation of Lugol's solution during endoscopic examination better defines these differences. Squamous epithelium stains black due to its glycogen content whereas columnar epithelium remains unstained.[14]

It is widely believed that adenocarcinoma in Barrett's esophagus evolves through a sequence of dysplasia and carcinoma-in-situ.[15,16]

When Barrett's esophagus is discovered, at least yearly endoscopic surveillance with multiple biopsies are indicated. Some authors favor an anti-reflux procedure in patients with reflux esophagitis and Barrett's esophagus.[17] In 1980, Brand, et al, reported the reversal of columnar esophageal epithelium to stratified squamous epithelium in four of 10 patients after anti-reflux operations.[18] Previous reports, however, indicated that fundoplication relieved symptoms but did not result in regression of the columnar lining nor prevent the development of adenocarcinoma.[9,19]

No one has definitely implicated the roles of excessive alcohol ingestion and/or smoking in the development of adenocarcinoma in Barrett's esophagus although they are considered important in the etiology of squamous cell carcinomas of the esophagus.[20,21,22]

It seems reasonable that when Barrett's esophagus shows dysplastic changes and reflux esophagitis is present, an anti-reflux operation should be advised. Alcohol intake and cigarette smoking should be discontinued.

With close endoscopic surveillance it is hoped that any adenocarcinoma will be found early, perhaps even in-situ, so that esophagectomy with an interposition procedure might have a chance for cure.[23] Adenocarcinoma of the esophagus has the same poor prognosis as squamous cell carcinoma with a five year survival of 2%. However, some patients with early diagnosis of Barrett's esophagus and adenocarcinoma have survived two to eight years after operative management.[22] More significantly, three patients resected for adenocarcinoma in-situ in Barrett's esophagus have been reported as apparent cures.[24,25,26]

Summary

The treatment of Barrett's esophagus with reflux is an anti-reflux procedure. The columnar epithelium in the esophagus has a malignant predisposition. If it persists after anti-reflux measures, periodic endoscopy with biopsy is indicated. It is hoped that by diagnosing adenocarcinoma while still in-situ, the dismal cure rates can be greatly improved.

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A Microcomputer Generated Individualized Pediatric Emergency Drug List

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RESPONSE time in any code situation is critical. One method typically used to reduce response time in the adult code includes the use of commercially available emergency drugs in ready-to-use adult dosage forms. Unfortunately, the critical time saved in the adult code scenario is often prolonged during a pediatric code because of the need to calculate individualized dosages before the medication can be administered by the nurse. Another type of time consuming drug-related problem is the preparation of intravenous piggyback medications which require flow rate calculations. These include lidocaine and dopamine drips. In either case, there exists a high probability for human error whenever dosages have to be calculated during this extremely high stress event.

In the past, we have tried to reduce response time at pediatric codes by utilizing different types of dosing sheets as those suggested in the literature.[1,2] Although such graphs preclude having to perform drug calculations, they do require time during a code, especially if necessary information such as body weight is unavailable. With the advent of microcomputers, a new approach has been developed and implemented at our hospital.

Methodology

Utilizing an Apple IIe® microcomputer, an ACECalc®* program was prepared by Pharmacy Services which calculates emergency medication dosages for children in critical condition (e.g. meningitis.) Drug dosages to be computer calculated and printed are a function of the patient's body weight, and the program is used for children ages six months up to twelve years. The list of medications included in the program was decided by members of the medical staff and dosage recommendations abstracted from the literature.[3-5]

The computer program consists of two portions. The first portion contains data entry of patient information including name, hospital number, room number, age and weight. The second part of the program consists of drug calculation information (see figure). Products are listed alphabetically and followed by information including how each product is supplied, dosage range and the specific dose to be administered IV push or slow intravenous infusion. The program also calculates the defibrillation voltage regulations based upon body weight.

Pharmacy is responsible for printing an individualized computer drug list for each child admitted or transferred to pediatric intensive care. The pharmacist obtains the required patient information from the nurse and then generates two printed copies. One copy is sent to the floor and is attached to the patient's medical records. The second copy is attached to the emergency drug box used by the pharmacists when responding to a "Code Charlie" as a member of the hospital's CPR code team.

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*Brand of electronic spread sheet similar to VisiCalc®.

Figure 1
Example Patient With Pediatric Emergency Drug List

Patient:	John Doe	**Weight:**	28.6 lbs
I.D. #:	12345		
Room:	ICU/CCU		
Age:	2		13.00 Kg
Date:	05-15-85		

DRUG	SUPPLIED AS	DOSAGE	DOSE
Atropine	1mg/10mL syr	0.01-0.08mg/Kg	1.3 - 10. mL
Calcium Chloride	1g/10mL syr	20mg/Kg	2.6 mL
Dextrose	50%, 25g/50mL syr	1-2mL/Kg	13 - 26 mL
Epinephrine	1:10,000 10mL/syr	0.1mL/Kg	1.3 mL
Isuprel - IVPB	1mg (5mL)/100mL	0.1-1mcg/Kg/min	7.8 - 78 mL/hr
Lidocaine - IVP	2%, 100mg/5mL syr	1mg/Kg	.65 mL
Lidocaine - IVPB	2g/250mL IVPB	10-50mcg/Kg/min	.98 - 4.9 mL/hr
Narcan	0.4mg/1mL amp	0.4-2mg	1. - 5. mL
Sodium Bicarbonate	8.4% 10mEq/10mL syr	1-2mEq/Kg	13 - 26 mL
Sodium Bicarbonate	8.4% 50mEq/50mL syr	1-2mEq/Kg	13 - 26 mL
Valium	10mg/2mL syr	0.3mg/Kg	.78 mL

Dopamine Infusion: 400mg/500mL IVPB (800 mcg/mL)

Rate (mL/hour)	Dose (mcg/Kg/min)
1	1
5	5
10	10
15	15
20	21
25	26
30	31
35	36

DEFIBRILLATION: 2 watt seconds/Kg (max of 100 watt seconds) 26 ws

Discussion

The microcomputer-generated pediatric emergency medication list has several advantages over other current methods of drug dosage guidelines. The most important feature of our program is the time-saving individualization of dosages. Other advantages include precalculated dosages and flow rates of drug infusions which save the nurse, physician and pharmacist valuable time, allowing for more rapid preparation and administration of medication during a code, minimization of any errors in calculating dosages, use of a data display format which is consistent and consequently more easily read, ability to generate multiple original copies, and program flexibility for patient and product changes if necessary. The program has been well accepted by intensive care nurses. In these potentially high-risk patients, having individualized dosages **beforehand** helps to reduce any pre-code staff apprehension. Another application for this program includes use of it by flight nurses in our Burn Trauma Unit who must travel by helicopter to retrieve a child suffering from serious burns. Prior to flight departure, an individualized drug dose list can be generated quickly and placed in the flight bag in case a code situation should occur.

Summary

In any critical care area it is important to be knowledgable of emergency drugs used. However, when the dose must be calculated based upon the patient's weight, as in the pediatric patient, this dosing program is proving to be a simple yet effective and valuable method in reducing response time, thereby alleviating stress and decreasing the risk of serious error.

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FRACTURE OF THE MONTH

Rapid Bone Destruction After A Stress Fracture In A Diabetic (Charcot) Foot

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IN a previous "FRACTURE OF THE MONTH," we discussed Charcot joint changes in the knee associated with tabes dorsalis.[1] In the foot, the most frequent cause of Charcot neurotrophic changes is diabetes, usually of the long-standing, insulin-dependent type. These changes occur so frequently after minor injury in the diabetic foot that they should be known by every physician who treats diabetes.[2] It is particularly important not to confuse neurotrophic joint changes with those due to osteomyelitis. The neurotrophic deformity with hyperemic vascularity can be healed using appropriate local treatment. In contrast, amputation is the frequent outcome for osteomyelitis in the ischemic diabetic foot.

Case Report:

A 42 year old woman, who suffered from insulin-dependent diabetes since the age of 13, sustained a mild stress fracture to her forefoot. Over a two year period she was treated sporadically with crutches or casts while her x-rays demonstrated progressive destruction of the tarsometatarsal joints (Figure 1). Her midfoot and arch collapsed and she developed a rocker bottom deformity (Figure 2). This lead to plantar ulcerations which were resistant to local debridement or antibiotics. Because of the presumptive diagnosis of osteomyelitis, below the knee amputation was suggested by her physician. The patient came to the University of Nebraska Foot Clinic for a second opinion. On physical examination she had a prominent rocker bottom deformity of her left foot with a bony prominence on the medial plantar surface causing a 3x2 centimeter ulceration. She had decreased sensation to light touch below both knees but her right foot had no deformity. After discussing the options of treatment with the patient, we chose to correct the rocker bottom deformity by an osteotomy through the midfoot, and fusion of the tarsometatarsal joints (Figure 3). The patient required prolonged antibiotic treatment for cellulitis and bedrest for three months following the procedure. However, by three months the plantar ulcer and the osteotomy had healed sufficiently to allow the patient to walk with the help of a depth in-lay shoe. She has continued to wear orthopedic shoes that accommodate for the structural changes in her feet. In five years since her foot was stabilized and the plantar prominence removed, she has had no further difficulties.

Discussion:

Traditionally the changes in Charcot joint are attributed to the loss of protective sensation. However this does not explain the fact that many patients do experience pain.[3] Also, as our present patient illustrates, the destruction will progress rapidly with minimal trauma and will not be prevented by protective cast support.[4] A more satisfactory theory is that based on neurovascular rather than neurotraumatic pathogenesis.[5] This theory holds that the autosympathectomy associated with diabetic neuropathy eliminates vasoconstrictive response to trauma. This allows pronounced hyperemia, bone resorption and progressive collapse and deformity of the foot after even minor injury. The pathology of this process includes a pronounced vascular reactive tissue supporting numerous osteoclasts and resorbing bone. The result is the atrophic joint destruction typical of the diabetic Charcot joint. Characteristically as the bone is

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*From the Department of Orthopaedic Surgery and Rehabilitation, University University of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, NE 68105

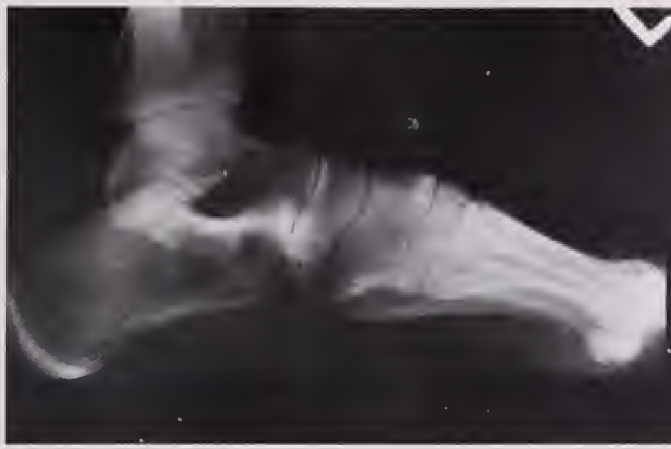

Figure 1A

A lateral x-ray at the time of initial treatment for a stress fracture at the base of the first metatarsal.

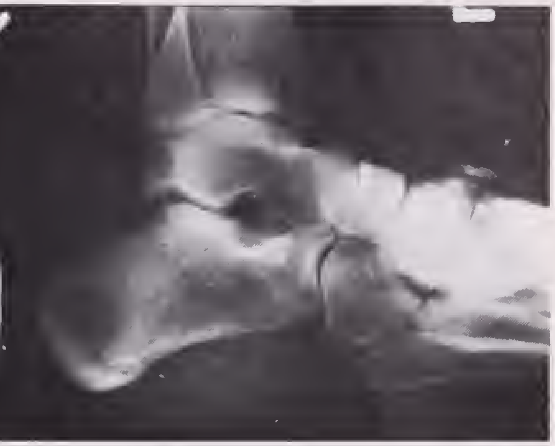

Figure 1B

A lateral x-ray five months later shows evidence of reactive bone resorption in the tarsometatarsal joint.

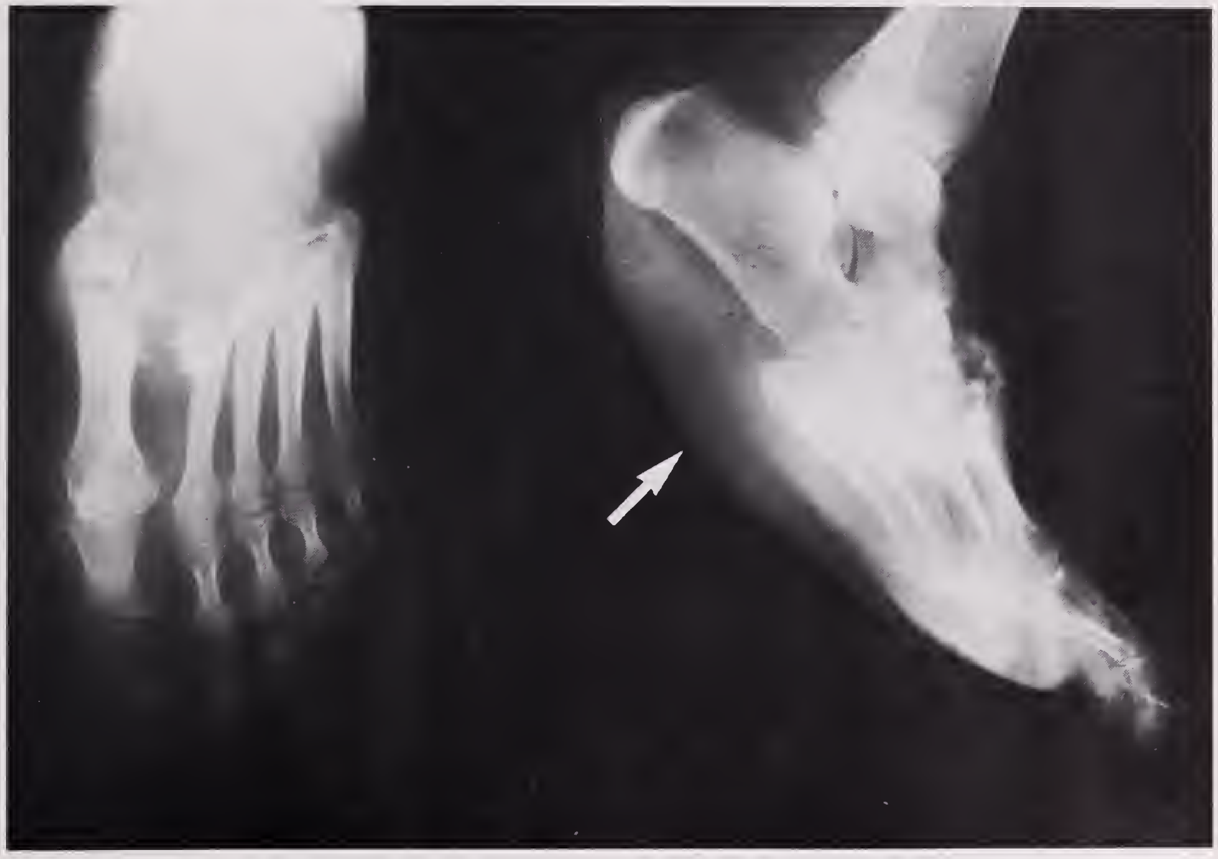

Figure 2A

Figure 2B

Anteroposterior and lateral x-rays two years after initial injury show destruction and dislocation of the tarsometatarsal joint. This causes rocker bottom deformity and plantar ulcerations (arrow).

resorbed, the foot and ankle become deformed. The therapeutic implication is that as long as bone resorption is taking place, even after minor trauma, the foot should be unloaded and elevated. This treatment should be continued until all inflammation and swelling has diminished clinically, and x-rays show signs of healing. It is also important that all diabetic patients, particularly those with long-standing insulin-dependent diabetes, are informed about

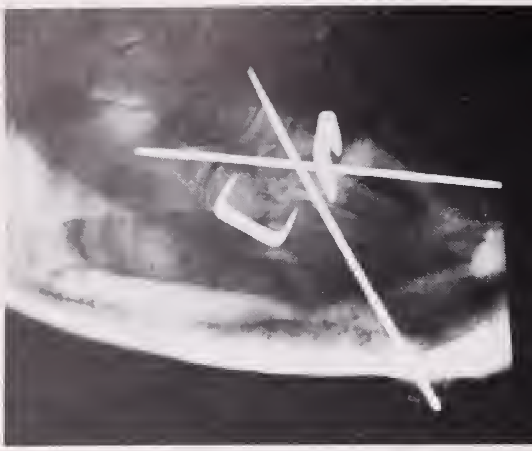

Figure 3 A

A lateral x-ray after the corrective osteotomy and fusion of the tarsometatarsal joint.

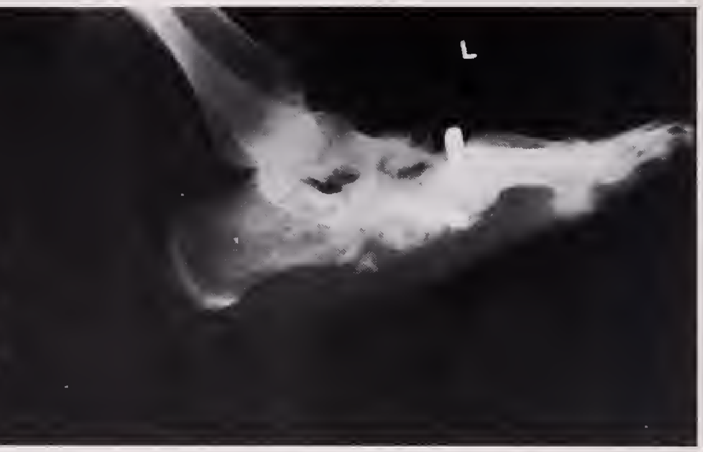

Figure 3 B

One and one half years after the operation the trasometatarsal joint has fused and the rocker bottom and plantar ulceration remain corrected.

the seriousness of minor injuries to their foot or ankle. After any trauma they should elevate the foot and ankle and minimize swelling with an active range of motion exercise. Weight bearing and dependent positioning of the foot should only be allowed after the swelling and hyperemia have subsided.

When the foot is seen with progressive neurotrophic destruction, the changes should not be confused with osteomyelitis. Local care and correction of the foot deformity can resolve the problem of neurotrophic ulceration and avoid the need for major amputation.

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CANCER UPDATE

Cervical Intraepithelial Neoplasia

Sponsored by the American Cancer Society
Editor: Dr. Gamini S. Soori, Omaha

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MOST practitioners caring for women are finding an increased incidence of dysplasia and carcinoma in situ (CIS) in younger women. Invasive carcinoma of the cervix causes 10 to 12 deaths per 100,000 women per year.[1] A standardized terminology, plus recommendations for screening and evaluation are essential to effect a decrease in the incidence of invasive cervical carcinoma. To accomplish this goal, understanding of the epidemiology, the recommendations for intermittent screening techniques, how to do a pap smear, and how to evaluate and treat an abnormal pap smear are important.

Epidemiology

Studies suggest that carcinoma of the cervix is a venereal disease. It is associated with early age of first coitus, multiple sexual partners, and/or a promiscuous male partner. Other factors which used to be associated with cancer of the cervix which have not been confirmed include circumcision[2] and birth control pills.[3]

Herpes and papilloma viruses are currently being studied as factors in cancer of the cervix. HSV-2 antibodies are found in a very high percentage of patients with invasive carcinoma as compared to controls.[4] It is also estimated that flat warts of condyloma accuminatum account for 80% of the mild dysplasias.[4] Which of the following possible associations of the virus and cancer of the cervix is correct is unestablished: 1) the viral infection precedes the neoplastic change and is actually a carcinogen, 2) the viral infection and the neoplasm are venereal diseases and independent, 3) the virus has an affinity for neoplastic tissue and the infection follows the neoplasm.[5]

Cytologic Screening Recommendations

There is much disagreement on how often women should have pap smears. The American College of Obstetricians/Gynecologists feels that "smears should be obtained from all women by the age of 18 and in those who have been sexually active regardless of age. Most patients with a negative initial report should undergo annual cytologic screening."[6] The American Cancer Society guidelines are as follows: "an asymptomatic woman age 20 and over, and those under 20 who are sexually active, should have a pap test at least every three years, after two initial negative tests a year apart." These recommendations may be modified depending on past history of dysplasia.[4]

How to Obtain Cytology and Interpret the Findings

The cytologic specimen should be obtained prior to the pelvic exam with a nonlubricated speculum with the cervix and vagina fully visible.[6] Separate sampling of the endocervix with a cotton tipped applicator and the portion at the squamous columnar junction with an Ayre spatula produces the highest rate of detection. Both specimens may be placed on one or two slides without clumping and fixed immediately to avoid air drying. Large amounts of vaginal discharge should be carefully removed prior to sampling. Small amounts of blood should not preclude sampling.

Pap smear results should return in a narrative form and adhere to the format recommendations by the Americal Society of Cytology and the International Academy of Cytology:[6]

- Unsatisfactory (cite reason and recommendation)
- No abnormal cells
- Mild squamous atypia
  - metaplasia
  - inflammation (with organism if identified)
  - regeneration and repair
  - radiation effect
  - viral effect
  - others (specify)
- Cytologic findings consistent with dysplasia
  - mild
  - moderate
  - severe
- Cytologic findings consistent with invasive squamous cell carcinoma
- Abnormal cells not specifically categorized (see comment)

Direct communication between gynecologist and cytopathologist is imperative.

Evaluation of Abnormal Pap Smear

Cytologic smears showing atypical cells require the physician to treat the specific cervicitis and repeat the smear in 3 months. If the smear is still atypical at 3 months, colposcopy should be done.

Smears suspicious for dysplasia or invasive squamous cell carcinoma require viewing the cervix for visible lesions and subsequent biopsy if present. If there are no visible lesions, colposcopic exam with directed punch biopsies and endocervical currettage should be obtained. Random four quadrant biopsies without evidence of lesions is not generally accepted. Conization is usually necessary if the following are present:[6]

1. results of the endocervical currettage are positive

2 cytologic assessment indicates an abnormality that is not consistent with the tissue diagnosis.

3. the entire transformation zone is not visible

4. microinvasive carcinoma is diagnosed by directed biopsy

5. in situ adenocarcinoma of the cervix is detected.

Cone biopsy evaluation may be needed if there is no colposcopically visible lesion and the abnormal tissue is thought to be in the canal or if the patient is deemed unreliable to follow-up.[4]

Treatment

After adequate evaluation to rule out invasive carcinoma of the cervix, a treatment program can be tailored. Local therapy requires that the lesion is on the ectocervix with no involvement of the endocervical canal and not be multifocal or severe dysplasia or greater. Treatment is usually individualized using local excision, electrocautery or cryocautery for small lesions. Carbon dioxide lasers and conization are used for larger lesions. Hysterectomy may be appropriate in those who wish sterility or have larger lesions that local treatment will not obliterate.

In summary, carcinoma of the cervix is detectable in early stages utilizing periodic screening of patients. Consultation between the pathologist and gynecologist should be frequent to assure understanding of smears and biopsies of the cervix. Proper evaluation and management of cervical dysplasia and CIS should be performed to effect a decrease in the amount of invasive disease. Repeating pap smears until normal without colposcope examination, biopsy or conization is not acceptable.

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LETTER TO THE EDITOR

Eighteen years ago I published the pioneer work on second hand tobacco smoke that reported that children residing with a smoker in the household probably suffered health damage. My subsequent research implicated health damage to spouses as well. I championed a number of social policy changes as a result of my research. Over time my results have been replicated by other scientists and almost all of my social policy recommendations regarding exposure to second hand tobacco smoke have been put into place.

While the tobacco interests criticized my findings and social policy recommendations, they never did so with the hostility or intellectual sloppiness of the two homosexual activists who attacked my article on "Sexual Orientation and Sexually Transmitted Disease" which appeared in the August issue of the Nebraska Medical Journal.

Joel Brodsky, a graduate student affiliated with the 'Gay Student Union' according to his department, took us to task for being "homophobic" and 'biased' and thus unable to conduct a worthy scientific study. None of the authors of the article is unreasonably afraid of homosexuals, so the charge of 'homophobic' appears groundless. As to 'bias', the only requirement for doing scientific research is that one conduct studies according to the rules of the discipline and be honest and open regarding procedures and findings. Scientists generally study what they find interesting or important, and they usually have a theory or hunch as to what will be obtained if their study is conducted. Requiring the "attitudinal purity" of neutrality would necessitate all scientific work being done by scientists uninterested in the issue — a patently silly stance. Curiously, Mr. Brodsky claims that he is engaging "in ongoing research" of some unspecified sort on homosexuality but would deny me the same privilege because I am 'biased'. It would seem that activist Bodsky wishes the power of censorship, not the free exchange of ideas and results that characterizes honest intellectual endeavor.

His charges of "distortions of the social science literature, and violations of professional ethics, are a matter of public record" is sheer poppycock. Had I "distorted" literature Mr. Brodsky would presumably have been able to specify at least one such event, his inability betrays the shallowness and ugliness of his posture. The charge of "violations of professional ethics" is similarly as false and groundless. Unless one is willing to believe that opposing "gay rights" is unethical, I have never violated any professional ethical code. That a disturbed student should be permitted to use the pages of a medical journal to baselessly impugn the reputation of a professional testifies to the sorry state of professional responsibility vis a vis homosexuality.

Another employee of the University of Nebraska, Scott Stebelman, details a number of 'charges' against the paper. He complains that I have called for the quarantining of males who practice homosexual acts until the AIDS crisis is resolved. I am proud to have been the first professional to take this stand publicly, and am confident that history will vindicate my position. It is, however, obscure as to how my opinion would either detract or add to the paper.

Stebelman criticizes our questionnaire as inadequate because:

1) it asked about numbers of homosexual virgins with whom one had had sexual relations (it also asked about numbers of heterosexual virgins). We included this question and a number of others for purposes of comparability with the Kinsey material.

2) he couldn't understand what we meant by "serious sexual advances" (however, only a handful of respondents indicated any difficulty with the concept in context),

3) it was obviously biased against homosexuality. We kept records of respondents who brought up the question of questionnaire bias in all cities but Louisville; of those who mentioned or wrote that the questionnaire was biased, 51 felt it was prohomosexual, 3 said it was biased, and 5 felt it was anti-homosexual. We designed the questionnaire to be as non leading as possible, yet to 'bend over backwards to placate pro-homosexual critics' when some tilt had to be registered, so I consider that we achieved our purpose very well (indeed 3 of the 5 who felt it was anti-homosexual cited this very tilt as the reason.) Most of the items

were taken from other sexual surveys to permit comparisons between our randomly-obtained and their volunteer samples. Further, Mr. Stebelman appears to have been criticizing some items from our second survey done in Dallas in 1984.

Stebelman says that in "1984 the American Psychological Association expelled him for unethical conduct". As a matter of fact, I resigned from the APA Nov. 7, 1982 with no charges announced and/or pending against me because I was disgusted with its pro-homosexual and pro-abortion stands. Thereafter, as a non-member, I refused to have anything further to do with any APA committees. Not willing to see me depart with such "unreasonable beliefs" the APA, on Dec. 2, 1983 notified me that the board of directors had "voted to drop you from membership in the Association for lack of cooperation with the Committee on Scientific and Professional Ethics and Conduct; this is a violation of the Preamble to the Ethical Principles of Psychologists." Supposedly, according to Stebelman, "the Nebraska Psychological Association has repeatedly rebuked him for misrepresenting research in the area." As I have never been a member of NPS nor have I ever received any notification of such a "rebuke" from NPS it is difficult to respond. Drs. Bell and Groth apparently do disagree with me, but neither has been specific as to empirical error on my part so I assume they are concerned with my non-support of "gay rights".

So the "gays" have had their say, and what do they have to bring forward? Rumors, vague charges of misconduct, speculations as to adequacy of sample. Indeed. The original Kinsey study used 997 volunteers and 477 randomly-obtained respondents. If the first Kinsey study could be graded an F+, and the second a D−, then the ISIS survey would appear to merit about a B−. The ISIS survey reported in the NMJ is far from perfect, but it is standard deviations superior to any other national study extant in terms of breadth and adequacy of sample.

Brodsky is so upset that he wants "resignation by those members of the editorial board responsible for this outrage" and Stebelman worries that publication "enhances the authority of bigots". The question professionals reading these exchanges might ask themselves is "why are these fellows so vitriolic?" I believe the answer is that those given to homosexual habits are disturbed people who do anti social things. For the last several millennia homosexual acts have been condemned as violative of good social order. Over the past 25 years we have rejected our ancestors' appraisal believing that modern sexologists had disproven the wisdom of their position. Recent experience with HBV, the gay bowel syndrome and AIDS should alert us to our error. Contemporary empirical material regarding human sexuality is middling at best, and those who build social policy upon it are anchoring to sand.

A deadly new lentivirus is loose in our midst. It is foolish to worry about supposed 'special civil rights of gays' when the lives of millions, perhaps even billions, hinge upon control and eradication of this deadly visitor. As our survey evidenced all too well, by defining promiscuity as a sacred right, our society has set itself up for a wasting epidemic.

Paul Cameron

President's Page

SEASONS GREETINGS

The word December comes from the Latin stem meaning tenth month. When our present calendar was put together in 1582 this oddity was overlooked as arrangements were made for 12 months, December being the last. This strange turn of events does not detract from the prime importance December holds for us. Aside from the solemn religious observance by some, this being the end of the year it is common place for many to review the past 12 months and evaluate the effects events have had on their lives.

To put it succinctly, the past year has been a turbulent one for the medical profession as drastic changes have taken place with unbelieveable rapidity, shaking the very foundation of medicine. Of great concern is the potential many of these actions have for a disastrous effect on the profession.

However, even at this early date there are slight indications appearing that might represent a harbinger of hope as the momentum has slackened and the coming year might restore some sanity.

A few leading politicians are sensing some of these programs are ill-advised and are recommending re-evaluation. Some experts in the health care field are issuing warnings that some actions are doing more harm than good with reference to the plight of the poor and elderly. More and more we are hearing the public's concerns about the fate of the quality in health care produced by the changes. There are indications the quality they desire and deserve is in jeopardy and they look to the medical profession for guidance. A few jurists and legislatures are taking a more realistic view of the chaotic conditions resulting from the present day professional liability situation. Recent polls show a rise in our profession's image.

Francis D. Donahue, M.D.

These are only scanty indications and in no way signify an end to this nightmare. It is, however, a message to the profession to continue to provide the best, most caring medical service possible in spite of the obstacles. The sick are deserving of nothing less and look to us, their advocates, to provide it. If we don't, no one will.

With this resolve we can end this year giving an added meaning and luster to the favorite seasonal greeting:

Merry Christmas to all.

Francis D. Donahue, M.D., President

The Auxiliary

1985 Leadership Conference! What a beginning! After attending this meeting in October in Chicago, the NMA Auxiliary officers and three county presidents-elect came back to Nebraska ready to conquer the world.

We have fresh new ideas from our idea exchanges with other auxilians from all over the United States. We are filled with current information regarding the changing trends in medicine and a motivation to be real leaders in an organization that is so vital to all physicians spouses.

Thanks a million for the opportunity to attend these meetings. We will try to share with all of you the information and ideas we have learned.

Report on Leadership Confluence 1985:

Educating and motivating! These are two words to describe AMAA's Leadership Confluence that I, as President-elect of Lancaster County Medical Auxiliary, was privileged to attend. I learned so much about the federation of the AMAA, leadership skills, and legislation and garnered many great ideas from other auxilians to bring back to our county and state auxiliaries.

Confluence expanded my horizons and showed me how our county auxiliaries fit in with the federation of the state and national Medical Auxiliaries — how our work and input helps AMAA goals and how AMAA helps us at state and county levels, with information and training resources and with expanded power of numbers. I saw what our AMAA dues were paying for and realized the need to increase the awareness of the benefits of AMAA membership.

From the speakers on leadership I learned about management styles, leadership skills, and parliamentary procedure.

The sessions on legislation and the causes of rising health care costs really raised my interest level. They pointed out how the image and income of our physician spouses are being affected by the national budget deficit and the resulting legislation — reduction of Medicare funding, cutbacks in health projects, and fee freezes for physicians. The rising number of malpractice suits and the resultant liability insurance increases hurt image and income of physicians and may effect the physicians self-image. Because of the effects legislation has on medicine, we need to be informed and aware of what is happening and do whatever we can to help. AMAA has brochures, newsletters, speakers and legislative experts available to help us at the grassroots level.

Now I and the five other NMA Auxilians who went to Confluence will try to use what we have learned to benefit NMAA and our county auxiliaries. Thank you for the opportunity to attend and learn.

Joyce Urbauer

Those attending the meeting were Ardis Grace, NMAA President; Bev Kruger, NMAA President-elect; Colleen Adams, NMAA 1st Vice President; Joyce Urbauer, Lancaster Co. President-elect; Penny Keim, MOMSA President-elect, and Cheryl Bergstrom, Dodge Co. President.

MEMBERSHIP ALERT!

The Nebraska Medical Association Auxiliary is a non-profit, volunteer force of over 800 physicians' spouses, dedicated to common goals and making a difference in the quality of life and health care in their communities.

In addition, auxiliary legislative committees are working to educate members in medical legislation in order to keep them up-to-date on health related issues. Our members have been made aware of legislation's importance to their spouses' profession . . . and they have worked at becoming better informed.

The strength of this vital organization lies in its numbers. For the third year, the AMA Auxiliary has given each state a "fair share" goal with regard to increasing national membership. This year, our goal is to increase national members by 44. With each District in our state working toward this goal, the challenge should easily be met.

Understandably, not all potential members can be "active". But, they can be informed and supportive. And, they can feel themselves to be a part of a dedicated network, whose members work individually and collectively to promote traditional concepts of responsbility and service to meet the health needs of our communities and nation. There are 80,000 members in the AMA Auxiliary . . . 80,000 people who find that membership doesn't cost . . . it pays to belong!

Colleen Adam
Membership Chairman

Coming Meetings

1986 ANNUAL SESSION — April 25-28 — Omaha Marriott

1986 FALL SESSION — Sept. 25-27 — Lincoln Cornhusker.

UNIVERSITY OF NEBRASKA

THIRD ANNUAL REVIEW & UPDATE — GENERAL PEDIATRICS AND FAMILY PRACTICE — February 26-March 5, 1986 at the Royal Waikoloa Hotel, Kona, Hawaii and March 5-12, 1986 at the Royal Lahaina Hotel, Maui, Hawaii. Sponsored by the University of Nebraska Medical Center and the Creighton University School of Medicine. Credit: 20 hours AMA Category I. Topics include: infectious diseases, adolescent medicine, allergies, rheumatology, and pediatric cardiology. Fee: $400, physicians and $250, residents/interns. Contact: Marge Adey, Center for Continuing Education, University of Nebraska Medical Center, 42nd & Dewey Avenue, Omaha, Nebraska 68105, Phone: (402) 559-4152 or Hattie DeLapp, Creighton University School of Medicine, Phone: 1-800 228-7212, ext. 2550.

UNIVERSITY OF NEBRASKA MEDICAL CENTER UPCOMING CONTINUING MEDICAL EDUCATION COURSES

February 17-22, 1986, Strategies in Oncology/Hematology for the Family Practitioner, Saddlebrook Resort, Tampa Florida.

February 26-March 5, 1986, Review and Update: General Prediatrics & Family Practice, Sheraton Royal Waikoloa, Kailua, Kona, Hawaii.

March 5-12, 1986, Review and Update: General Pediatrics & Family Practice, Royal Lahaina, Kaanapali Beach, Maui, Hawaii.

March 2-7, 1986, 6th Annual Keystone Medical Ski Conference "Diagnostic Dilemmas - The Approach and the Answers", Keystone Lodge, Keystone, Colorado. This course is held in conjunction with the Dental Ski Conference and the Nursing Ski Conference.

April 14-25, 1986, Family Practice Revew.

May 5-16, 1986, Family Practice Review.

June 29-July 3, 1986, Update on General Pediatrics, Jackson Hole, Wyoming.

June 7-10, 1986, Sports Medicine Update, Jackson Hole, Wyoming.

July 23-26, 1986, Lake Okoboji Sports Medicine Conference, Lake Okoboji, Iowa.

For further information, contact Marge Adey, University of Nebraska Medical Center, Center for Continuing Education, 42nd & Dewey Avenue, Omaha, Nebraska 68105. Phone (402) 559-4152.

CREIGHTON UNIVERSITY

CARDIOLOGY FOR THE NON-CARDIOLOGIST — Aug.-Dec. 1985. Program Director: Michael H. Sketch, M.D., Division of Cardiology, Creighton University. 13 hour Category I, 13 Prescribed hours by the AAFP. Fee: $195.00. Series I — Coronary Heart Disease and Arrhythmias: Aug. 1-4 Southampton Princess, Bermuda; Oct. 25-27 MGM Grand, Las Vegas, Nevada; Dec. 6-8 Sheraton Yankee Clipper, Ft. Lauderdale, Florida. Series II — Arrhythmias: Interpretation, Diagnosis and Management: Aug. 16-18 Orlando Hyatt Hotel, Orlando, Florida; Nov. 22-24 Ramada Renaissance Hotel, San Francisco, California. For information: Division of CME, Creighton University School of Medicine, Omaha, Nebraska 68178. (402) 280-2550.

UNIVERSITY OF KANSAS

For information concerning the following continuing education offerings sponsored by the University of Kansas Medical Center contact: Carole Rosen, Promotions Coordinator, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, KS 66103 (913) 588-4480.

A SPECIAL WORKSHOP ON THE USE OF CO_2 LASER IN ENT SURGERY — Jan. 30, 31, and Feb. 3, 1986, Apr. 10, 11 and 14, 1986, Sept. 25, 26, and 29, 1986, and Dec. 11, 12, and 15, 1986 (3rd day optional - O.R. instruction). Sponsored by the University of Kansas Medical Center. Located at Sudler Hall, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas. 15 hrs. AMA (cat.l), 9 hrs. or .9 American Nurses Association. Fees 2 days $750 physicians, $300 nurses; 3 days (includes O.R. instruction) $900 physicians, $350 nurses.

MEDICAL ETHICS — March 7, 1986 at Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Boulevard, Kansas City, Kansas.

ANNUAL POSTGRADUATE PEDIATRICS SYMPOSIUM — March 12-13, 1986 at Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

SAM E. ROBERTS NUTRITION SYMPOSIUM — March 25, 1986 at Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

AIDS: ARE YOU AT RISK? March 28, 1986 at Battenfeld Auditorium, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas.

COMMON GASTROENTEROLOGY PROBLEMS — April 1, 1986 at Alameda Plaza Hotel, Wornall Road at Ward Parkway, Kansas City, Missouri.

AMERICAN MEDICAL SOCIETY ON ALCOHOLISM AND OTHER DRUG DEPENDENCIES — April 18-22, 1986 at the Westin St. Francis Hotel in San Francisco, California. Information may be obtained by writing AMSA DD, 12 West 21st Street, 7th Floor, New York, New York 10010.

SCHEDULED MEETINGS

32ND ANNUAL SCIENTIFIC MEETING — NEBRASKA OB-GYN SOCIETY — December 5, 6, & 7, 1985, MGM Grand Hotel, Las Vegas, Nevada. 9 hours credit. Registration fee $200. Contact: Dennis Beaver, M.D., 720 N. 87th Street, Omaha, Nebraska 68114 (402) 390-1200.

THE NEBRASKA CHAPTER OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS will hold their 38th Annual Scientific Assembly, April 11 and 12, 1986 at the Marriott Hotel, Omaha, Nebraska. Contact: Phyllis Hansen, Executive Director, Nebraska Academy of Family Physicians, 401 No. 117th, Suite 202, Omaha, Nebraska 68154 (402) 333-5856.

REPORT OF OFFICERS, DELEGATES AND COMMITTEES

FALL SESSION
September 19, 20 and 21, 1985

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports.)

REPORT OF THE BOARD OF DIRECTORS

Francis D. Donahue, M.D., Omaha · Chairman; Hiram Walker, M.D., Kearney; Herhert E. Reese, M.D., Lincoln; Robert F. Shapiro, M.D., Lincoln; Donald J. Pavelka, M.D., Omaha; L. D. Cherry, M.D., Lincoln; Richard Raymond, M.D., O'Neill; Harry W. McFadden, M.D., Omaha; Alvin A. Armstrong, M.D., Scottsbluff; Stanley M. Truhlsen, M.D., Omaha.

The Board of Directors presents the following items as its report to the House of Delegates.

1. MEMBERSHIP REPORT: The Board continues study of the membership statistics both past and present. Membership continues to show growth in line with increased physician population in the state.

2. UNIFIED MEMBERSHIP: The American Medical Association's House of Delegates has over the years, discussed the virtues of unified membership (County/State/AMA). The subject was given intensive consideration at the June, 1985, Session of the AMA House of Delegates. Incentives for states having unified membership in the form of reduced dues to the AMA were included in the House of Delegates' action at that time.

The AMA House of Delegates is aware of the benefits derived when a high percentage of state association members are members of the AMA. The Nebraska Medical Association has a third delegate seated in the AMA House of Delegates based on the fact that 75% of the NMA members are also members of the AMA. This count also includes Life Members, Student Members and House Officer Members.

The Board of Directors discussed the subject of unified membership at length and recognized that the Association had a unified membership policy until 1972. Recent years have produced reason after reason as to why medicine's voice must be united. The American Medical Association has long represented all physicians practicing in this country and the Association needs the input and support of the highest number of physicians obtainable.

Oklahoma and Illinois have had unified membership for many years and Kansas recently approved this approach. Several other states are currently considering a return to a unified approach and the Board of Directors feel Nebraska should also consider this possibility.

The Board of Directors approved a motion that the issue of unified membership be forwarded to the House of Delegates with a recommendation for adoption, and that the proposal carry the endorsement of the Board.

3. MANPOWER REPORT: The Board considered its annual Physician Manpower Report. Statistics indicated that 17 Nebraska counties showed a decrease in physician manpower, 38 showed an increase, and 38 had no change. Estimated population figures showed that 14 counties had a decreasing population while 79 had an increasing population. Eighteen counties have no physician. The average age of Nebraska physicians in 1985 is 47. Thirty-three percent of Nebraska's physicians are under age 40.

There are 2,066 practicing physicians in the state. Physician-to-population ratios appear as follows: 1985, 1 to 786; 1980, 1 to 857; 1970, 1 to 933.

It is evident that the number of physicians is keeping pace with or exceeding the growth in population in Nebraska just as reports have indicated the case to be in other portions of the country.

4. The Board considered the increasing concern regarding those mechanisms which are affecting and even altering the care of the aging. Mechanisms such as DRGs are definitely having an impact on the care of this category as are other processes and approaches to care. The Board is very firm in its opinion that physicians are the patients advocate and for this reason an Ad-Hoc Committee on Geriatrics has been formed.

5. The Board discussed the Pre-Admission Certification Programs now being implemented in Nebraska. It was decided that a letter clarifying the Association's concerns regarding the implementation of these types of programs of coverage be mailed to NMA members. This was done in August. In addition, a draft of wordage which physicians could use in informing patients covered by such policies of medicine's concerns with these types of coverages was included in the mailing.

An editorial on the subject will appear in the October issue of the Nebraska Medical Journal.

REPORT OF THE DELEGATE TO A.M.A.

The highlight of the 1985 Annual Session of the House of Delegates meeting — for the NMA — has to be the election of Jerry Schenken to the Board of Trustees of the AMA. This marks the first political endeavor of the Nebraska Delegation in many years. Jerry's campaign was managed by Jack Coe, assisted by the entire Nebraska Delegation and NMA staff with super support from the North Central Medical Conference and the College of American Pathologists. Doctor Schenken was elected to a full 3-year term on the Board, on the first ballot. He has joined by Rufas Broakway of Florida who was re-elected and by Lonnie Bristow of ASIM, Ray Scalettar of Washington, D.C. and John Tupper, a former Nebraskan, from California. Jack Rogers of Atlanta was inaugurated as the 140th President of the AMA and John Coury of Michigan was selected as President-Elect.

The issues of this session were over-shadowed by the professional liability problem facing several of our states, particularly New York and Florida. A copy of the report of the AMA's task force on professional liability which focuses mainly on the plight of the physicians who practice obstetrics in Florida is appended to this report. Substitute Resolution #149 as follows was adopted:

> "RESOLVED, that the American Medical Association Board of Trustees urge the Special Task Force on Professional Liability and Insurance to consider all appropriate means to inform the general public of the current and potential harm to the general public if the

present system of medical liability remains unimproved; and be it further.

"RESOLVED, that the AMA and component medical societies modify or develop alternate methods to the court/jury system whereby parties who have been injured through negligency receive just remuneration without adversely affecting the entire health care delivery system."

The physicians of Illinois were flush with their recent victories in their Legislature which had occurred just prior to the meeting. They mounted a massive legislative campaign and were successful in getting 11 of 13 bills approved but unfortunately where unable to get a cap on awards. There were 16,000 physicians in Illinois and 44,000 lawyers, with many trial lawyers in the Legislature. Over 4,000 physicians descended on the Legislature at the critical time of the date and needless to say, they got the Legislatures' attention.

It appears that the public is finally beginning to realize that unless relief is forthcoming in the professional liability area, access to service will become increasingly limited. With obstetrical, orthopedic, and neurosurgical services already being markedly reduced, particularly in New York and in Florida. (We continue to benefit from one of the best professional liability statutes in the country even though it too has some imperfections that must be addressed.)

Physician manpower and the projected physician surplus continues to demand a lot of attention and resolutions (#47, #97, and #98). Substitute Resolution #47 was approved which directed the AMA to form a task force to study the supply and distribution of physicians and the effects on cost of medical care.

Nebraska Resolution #64 was considered together with Resolution #29 and Substitute Resolution #29 which directed the AMA to continue to monitor the Administration Budget and proposed legislation affecting medical student financial aid and press for adequate funding was adopted.

Report I of the Board of Trustees came in response to Nebraska's Resolution #5 at the 1984 Interim Session requesting the AMA to develop and enhance the benefits package that accrues to AMA members only, and a copy of the report is appended. Participation in one or more of these programs could save physicians up to or exceding the entire cost of AMA dues. The AMA's retirement fund (IRA and Keogh) is up 138% over the past 5 years. There will be a dues increase for 1986 which will amount to about 6-8 cents per day depending on our tax bracket. The range and quality of services provided by the AMA to its membership has to be one of the best bargains going.

It was reported that Kansas and Louisiana have recently voted for unified membership, requiring all members of the state association to belong to the AMA. They join Oklahoma and Illinois who have been unified for years. There are special benefits resulting from unified membership which include a 10% dues reduction, an additional AMA delegate, and some special services provided to the state association by the AMA which are not provided to non-unified states. Perhaps the time has come for the NMA to reconsider unified membership, which we gave up in 1971.

Other issues of particular interest are as follows:

1. Amended Resolution #86 along with Resolutions #45, #55, #79, and #86, were referred to the Board of Trustees for review and report. Resolutions #45 and #79 opposed pre-admission certification and prior authorization programs. Resolution #55 called for the development of a uniform pre-admission certification form for use with all third party payment. Resolution #86 asked the AMA to study these programs and the problems created by the lack of uniformity in such programs. Substitute Resolution #86 recommended by the Reference Committee is as follows:

"RESOLVED, that the American Medical Association conduct a study of preadmission certification programs, prior authorization programs and the problems created by the lack of uniformity in such programs and cost effectiveness of such programs, and be it further

RESOLVED, that a report of the findings of the study be provided to the House of Delegates at the 1985 Interim Meeting which would include a uniform criteria for preadmission certification and prior authorization programs."

2. Substitute Resolution #101 which reads as follows was adopted:

"RESOLVED, that the American Medical Association notify insurers that the AMA considers it the responsibility of insurers to develop uniform descriptive materials to inform their insureds of restrictions or conditions for prior authorization of services, such as identification cards already developed by some carriers; and be it further

RESOLVED, that it be the policy of the AMA that it is the responsibility of the insured or insurer to properly notify a physician of any preauthorization requirements prior to the rendering of a service."

3. Resolution #18 which asked that the AMA urge HCFA to make direct payments for medical care to the provider whether or not the provider accepts assignment, with a notice of payment sent to the patient was adopted.

4. Amended Resolution #23 was adopted:

RESOLVED, that the American Medical Association continue to support appropriate national legislation for government compensation of any person seriously injured as a result of mandated immunization."

5. Resolution #12 directed to AMA to urge the Congress to favor an amendment to the U.S. Constitution requiring the establishment and maintenance of a balanced budget.

6. Resolution #13 which called on the AMA to support a Constitutional Amendment allowing Presidential line-item vetoes was adopted.

7. Substitute Resolution #99 was adopted:

"RESOLVED, that the American Medical Association direct its members on the Accreditation Council for Graduate Medical Education to request the Council to consider a change in the "Essentials for Accredited Residencies" that would recommend the allocation of time for educational programs on issues such as (a) medical liability and malpractice, (b) practice managment, and (c) economics of practice."

8. Substitute Resolution #77 was approved as follows:

"RESOLVED, that the American Medical Association oppose federal supports to the tobacco industry and urge Congress to end such support."

9. Resolution #37 as adopted asked the AMA to make a major effort to coordinate and strengthen its anti-smoking activites and cooperate with other agencies to promote a smoke-free society by the year 2000.

10. Resolution #125 as adopted asked that the AMA restrict smoking during staff meetings and conferences within its headquarters building and only allow smoking by employees in designated areas and assist and encourage those employees who desire to stop smoking.

11. Resolution #27 which requested the AMA to oppose any type of National Mandatory Fee Schedule and to discourage current efforts to conceive or implement such a fee schedule was adopted.

12. Substitute Resolution #43 was adopted which reads as follows:

> "RESOLVED, that the American Medical Association support legislation amending the current federal law so that employers must offer multiple options for health care benefits to employees or to their union representatives including the traditional fee-for-service coverage option if a health care benefit is provided."

13. Amended Resolution #90 was adopted as follows:

> "RESOLVED, that the American Medical Association monitor the Medical Association of Georgia Independent Practice Association/Health Maintenance Organization (IPS/HMO) plan, and any other similar plans, to determine if their widespread use would be beneficial."

14. Adopted amended Resolution #105 as follows:

> "RESOLVED, that the American Medical Association urge Congress to change existing law regulating appeals under Utilization and Quality Control Peer Review Organization programs (PRO) to entitle physicians to initiate administrative hearing or judicial review of an unfavorable reconsidered decision by a PRO."

15. Approved amended Resolution #121 as follows:

> "RESOLVED, that the American Medical Association, in a manner it deems most appropriate, encourage insurers to develop and provide additional death benefits on the basis of the deceased's use of a safety belt at the time of a fatal automobile accident."

Your AMA Delegation would like to thank all who contributed to our successful effort in electing Jerry Schenken to the AMA Board of Trustees. It was a real team effort including an outstanding job by Ken, Bill and our headquarters staff.

Once again, it has been my pleasure to represent the NMA in the AMA House of Delegates. Your suggestions, comments and counsel are most appreciated.

Respectfully submitted,
C.J. Cornelius, Jr., M.D.
Delegate

REPORT OF THE BOARD OF TRUSTEES

Report: AAA
(A-85)

Subject: Special Task Force on Professional Liability and Insurance

Presented by: John J. Coury, Jr., M.D., Chairman

Referred to: Reference Committee B, (Malcolm O. Scamahorn, M.D., Chairman)

In Board of Trustees Report EEE (A-84), the House of Delegates was informed that the Board authorized the AMA Executive Vice President to create a Special Task Force on Professional Liability and Insurance. The Task Force has coordinated and intensified AMA activities in the area of professional liability.

In Board of Trustees Report K (I-84), the Task Force reported to the House of Delegates on several of its activities. The initial project was the three reports entitled **Professional Liability in the 80s.** These reports were distributed to all AMA members as an insert in **AM News**. Over 5,000 copies of the reports have been distributed to press, government officials, business and various national organizations. Ten thousand additional reports have been bound under one cover and currently are being provided to health policymakers, federation members and a broad array of other groups.

Special Task Force Recommendations

The specific recommendations of the Task Force to deal with the professional liability crisis were included in report three of **Professional Liability in the 80s,** inserted in the March 22, 1985 edition of **AM News.** This "action plan" was presented to and approved by the Board of Trustees at its February 1985 meeting.

The action plan listed recommendations in four categories: education and community action; legislation; defense coordination; and risk control and quality review. The Task Force has begun to implement this plan.

1. Education and Community Action

The first category, education and community action, is designed to make the public aware that the professional liability crisis is not just a physician issue. The public has a vital stake in the professional liability crisis from the standpoints of cost, quality and access to medical care. The Task Force and its reports have been effective in turning national attention to the problem. A national issue has been created. Members of the Task Force have appeared on numerous national television and radio programs. Editorials citing AMA's statistics and reports have appeared in most major newspapers and magazines.

On June 3, the Task Force sponsored a nationwide teleconferencing program. The program was broadcast to over 350 sites. The teleconferencing highlighted the professional liability activities of California, Illinois and the anesthesiologists, provided information on AMA activities and recommendations and included a discussion by a panel consisting of an insurance company executive, a prominent defense attorney and Doctor Todd. The program's co-moderator was Doctor Sammons. Tapes of the conference are available to interested physician and nonphysician groups.

The Task Force has sent copies of its action plan to virtually every national organization with an interest in health care. These organizations include the AFL-CIO, National Legal Center for the Public Interest, American Enterprise Institute, Brookings Institute, Heritage Foundation, American Association of Retired Persons, Hastings Center, Rand Corporation, National Association of Insurance Commissioners, Defense Research Institute, American Hospital Association, Blue Cross/Blue Shield Association, Health Insurance Association of America, Dunlop Group of Six, various government agencies and others involved with this issue. The Task Force has met with several of these organizations to discuss its recommendations and has obtained substantial support.

The Task Force and other AMA officers and staff routinely seek out and speak to diverse groups on the professional liability issue. Speakers have presented this issue at medical society meetings, to state task forces, commissions and legislative committees, and at national conferences.

Data collection to document the crisis and to refute the misrepresentations by others is essential to public education. In addition to the **Professional Liability in the 80s** reports and daily responses to press inquiries about data, the Task Force is in the process of completing a detailed, comprehensive rebuttal to the numerous factual distortions purveyed by groups that are benefiting from the crisis. This analysis will be distributed to the federation and national media.

Other activities that will bring this issue to the public have been completed. The Task Force, in conjunction with the AMA Department of Consulting Services, prepared an issue packet on professional liability. The packet was distributed to the federation and is available on request to individual members who will serve as advocates on this issue. The packet includes background data, a speech outline and sample editorials.

In addition, the Task Force, along with the AMA Washington Office, has met with medical specialty society Washington representatives. The AMA's recommendations on the professional liability issue were presented. A follow-up conference with specialty society leadership is being planned to develop a constructive national approach to legislation and risk management.

The Task Force has prepared a pamphlet for patients that explains the current professional liability situation and its impact. The pamphlet is entitled "Doctor, Why Am I Hearing So Much About Professional Liability and Malpractice Today?" It describes in straightforward, everyday terms the real nature of the crisis. It can be obtained through the AMA's Order Department. In addition, the film for the pamphlet is available to medical societies, so they can reproduce the pamphlet for their members.

The Task Force has contacted many coalitions involved with efforts to contain health care costs. In conjunction with the AMA Department of Health Care Coalitions, the Task Force has distributed copies of **Professional Liability in the 80s** to 200 health care coalitions and to 150 corporations involved in the corporate visitation program.

In addition, the Department of Health Care Coalitions and the Task Force are in the process of preparing a professional liability handbook for coalitions. The handbook will include background information, information on how to present this subject to an existing coalition, potential coalition members, and a bibliography.

The Task Force has expanded the AMA's role as a national clearinghouse. In conjunction with the AMA's Division of Medical Society Relations, it sent the action plan to all state medical societies and specialty societies. The information provided to state medical societies also included materials produced and provided by the Kansas Medical Society about professional liability. Other states have begun to provide data and information about the professional liability issue in their states. In addition, the Task Force is working with other AMA divisions to develop and distribute current and reliable data on this subject.

2. Legislation

The second category of recommendations in the Task Force action plan involved legislation. The Task Force is proposing federal legislation which provides substantial incentives for states to pass and retain key tort reforms. The Council on Legislation has approved a draft bill.

The incentive bill provides federal grants to states that enact specified reforms. The reforms are those that promise the greatest savings for the federal and state governments, improve the efficiency and cost effectiveness of the tort system, and recognize the responsibility of the medical professional for self-policing. The reforms include periodic payments, collateral source offsets, limits on noneconomic damages, decreasing sliding scale for attorney fees, and self-policing provisions. There is broad national interest in tort reform. The reforms designated in the federal bill are equally valid for any kind of tort action.

In the action plan the Task Force identified other tort reforms designed to improve the liability resolution system and refine the method of awarding damages. The Task Force will work with states to encourage enactment of these reforms.

In addition, the Task Force is continuing to examine alternative liability resolution systems. The Task Force's primary thrust will be to improve the current tort system. However, it recognizes that alternatives may be developed that could enhance the efficiency of patient compensation without lowering the quality of medicine or unduly burdening one segment of society.

3. Defense Coordination

The third category of recommendations is defense coordination. The Task Force will provide information and expanded services to members and their attorneys to defend against professional liability lawsuits.

The toll-free telephone number, operating since late 1984, has responded to over 500 telephone inquiries. The Task Force has met with representatives of the Defense Research Institute (DRI) to develop areas of possible cooperation. Through DRI, the Task Force will be able to provide members with information on expert witnesses and access to briefs. The possibility of co-drafting pamphlets that explain the legal system, the role of the expert witness, and other legal issues are being explored.

The Task Force is assembling a panel of prominent defense attorneys. These attorneys will assist the Task Force and the AMA in implementing the recommendations in the action plan as well as in other activities involving professional liability.

4. Risk Control and Quality Review

The fourth category of recommendations is risk control and quality review. These recommendations recognize that the AMA has the ability to become the national clearinghouse on claims data and information and on risk management systems. In addition, they recognize that the medical profession is and should be the primary impetus for peer review and quality of care review.

In conjunction with the Physician Insurers Association of America and other organizations, the Task Force, American Medical Assurance Company (AMACO), and AMA Center for Health Policy Research will collect and analyze claims data, help to isolate specific and broad causes of liability, and develop methods to eliminate those causes.

The Task Force has met with other organizations involved in risk control activities. Data gathering and data sharing programs are being developed. Risk control models are being evaluated.

The AMA will continue to assist state medical licensing and disciplinary boards in identifying physicians who have lost their license in one state but remain licensed to practice in another. In addition, through the federal incentive legislation, funding would be provided to insure that state medical licensing and disciplinary boards have the staff and resources necessary to fulfill their legal responsibilities. The Task Force will continue to encourage state medical societies and hospital medical staffs to report flagrant and recurring negligence to state medical boards.

The AMA has created the Office of Education Research. One of its functions will be to examine adverse actions taken by state medical boards against physicians to determine whether any relationship exists to the physician's education performance or background. This information will be provided to the academic community. In addition, the Task Force, in conjunction with AMACO, will sponsor a series of roundtable discussions on professional liability issues. The first discussion is scheduled for early this fall. Topics will include reinsurance, insurance accounting and risk control activities.

The Task Force's activities will assist the AMA in its efforts to fight for high quality medicine while recognizing that competition and cost containment are permanent aspects of the practice of medicine. Cost containment measures can increase professional liability exposure and reduce the quality of care, if they are arbitrarily aimed at cutting costs. Physicians must be leaders in cost containment and utilization review activities. The information gathered by, and the activities of, the Task Force can be used to achieve this goal.

The Task Force's recommendations are the first step towards creating a climate in which physicians can provide high quality care without fear of undue liability exposure. The recommendations are designed to create a system in which victims of actual negligence can be fairly and efficiently compensated.

The recommendations are a blueprint. Other issues that arise will be incorporated into the Task Force's activities.

REPORT OF THE BOARD OF TRUSTEES

Report:00
(A-85)

Subject: Study of Professional Liability Problems Facing Problem-Plagued Specialty and State Medical Association

Presented by: John J. Coury, Jr., M.D., Chairman

Referred to: Reference Committee B, (Malcolm O. Scamahorn, M.D., Chairman)

Following adoption of Substitute Resolution 8 at the 1982 Annual Meeting, the Board of Trustees and the Speaker of the House appointed a ten-member Committee on Professional Liability to carry out the requested study of direct and indirect costs of professional liability. The Committee submitted its first report to the House of Delegates at the 1983 Interim Meeting. Following enlargement of its charge the Committee submitted a second report at the 1984 Interim Meeting with a summary of tort reform statutes and their treatment by the courts following the 1975 professional liability crisis as well as a discussion of trends that may accelerate the number of claims.

The Committee on Professional Liability consists of the following members:

George E. Collentine, M.D.—Council on Medical Service
William D. Dolan, Jr., M.D.—Council on Scientific Affairs
William E. Jacott, M.D.—Council on Medical Education
Ralph M. Milliken, M.D.—Appointed by the Speaker
William W. Moore, M.D.—Appointed by the Speaker
E. James Potchen, M.D.—Council on Medical Education
Russel J. Rowell, M.D.—Council on Legislation
Raymond Scalettar, M.D.—Chairman—Council on Medical Service
William C. Scott, M.D.—Council on Scientific Affairs
P. John Seward, M.D.—Council on Legislation

When it met at the 1984 Interim Meeting, the Committee on Professional Liability decided to study the professional liability problems of a problem-plagued specialty, obstetrics and gynecology, and a state medical association, the Florida Medical Association. Since the 1984 Interim Meeting, the Committee has met twice with representatives of the American College of Obstetricians and Gynecologists (ACOG), the Florida Medical Association (FMA), the American Medical Assurance Company and the AMA Special Task Force on Professional Liability and Insurance and has received materials prepared by ACOG and FMA. Based upon this study, the Committee on Professional Liability submits the following report on the professional liability problems plaguing the obstetricians and gynecologists and Florida physicians, recognizing that both groups are facing a crisis involving both affordability and availability of professional liability coverage.

PROBLEMS FACING OBSTETRITIONS AND GYNECOLOGISTS

Affordability and Availability of Professional Liability Insurance

ACOG is concerned about the continuing availability of insurance coverage for its members. In February, ACOG was informed that Pacific Employers Insurance Company would discontinue writing coverage for its group professional liability program at the end of April 1985. The group program provided coverage for 750 members of ACOG practicing in 45 states. ACOG was informed that a three-month moratorium would be put into effect during which renewal of coverage for a period of one year would be available; no new insureds would be underwritten; and the program would terminate at the end of three months.

The reduced capacity in the reinsurance markets in the United States and Great Britain, along with increased rates, is having an impact on the affordability and availability of professional liability insurance coverage for obstetricians and gynecologists. The Skandia America Group has discontinued writing reinsurance in the United States. General Reinsurance Company has discontinued writing reinsurance for obstetricians not previously covered but will continue to write reinsurance for renewals. With the decreasing capacity in the reinsurance market and the increased costs, Medical Protective Company has announced that the maximum policy limits that it will write in 1985 are $200,000/$600,000 and that it is enforcing strict underwriting standards for coverage of obstetricians and gynecologists, with substantial increases in premiums in the states in which its coverage is available. The Medical Protective Company limits are inadequate for obstetricians and gynecologists who practice in hospitals that condition staff privileges on proof of $1 million coverage. Insurance Corporation of America discontinued writing coverage for obstetricians and gynecologists as of December 31, 1984, and the Texas Medical Insurance Trust instituted a $2 million policy limit. These developments, coupled with high increases in premiums, have led ACOG to believe that an availability crisis is imminent.

Earlier this year, ACOG did a telephone survey of the mature premium rates for obstetricians gynecologists in California, Florida, Illinois, New York and Texas. ACOG has also conducted informal surveys of physician-owned professional liability insurance companies on premium differentials between coverage for the practice of OB/GYN surgery and the practice of gynecology only. The information is included in Appendix A attached to this report.

Increasing premiums and higher differentials in premiums for obstetricians and physicians who limit their practice to gynecology are accelerating the number of obstetricians and gynecologists who are discontinuing any obstetrical practice. Precise figures are not available, but estimates range from 10% to 35%. The AMA has received calls from three obstetricians who have been unable to obtain any insurance coverage for 1985.

Expanding Tort Theories Fashioned by the Courts

Unlike the law of contracts and property, where stability and predictability are of great importance, much of the law of torts deals with accidental and unplanned injuries and is produced primarily by judges following common law traditions. As a result, tort law tends to expand as creative lawyers and judges fashion new theories of recovery. Courts can review experience over time with various problems of liability and the factual situations in which they arise and have a basis for determining how well the rules of recovery serve the interest of society. Courts do not have the advantages of public hearings to determine whether administrative machinery could better address the problems of liability and recovery in the manner that a legislature does.

One example of the role of the judiciary and creative attorneys is the development of theories of recovery for manufactured or processed products. In 1842, an English decision established the principle that a party injured by a manufactured product must have privity of contract with the defendant manufacturer or processor to permit recovery. Exceptions were then developed by the courts for products characterized as imminently or inherently dangerous, so that by 1916 courts in this country followed the rule that a manufacturer may be held liable without a contract between the injured person and the manufacturer for the sale or repair of the product that caused the injury. The rule of strict liability then followed first for food and drink and later for products intended for intimate bodily contact.

By 1963, the courts abandoned camouflaging exceptions and stated openly that "a manufacturer is strictly liable in tort when an article he places on the market, knowing that it is to be used without inspection for defects, proves to have a defect that causes injury to a human being." No proof of negligence is required in strict liability cases. Currently, the courts are struggling with the definition of defect, the role of warnings, the effect of modifications of a product, what constitutes misuse of a product and the effect, if any, to be given to fault on the party of the injured person.

With the Diethylstilbestrol (DES) cases filed by daughters of mothers who took the drug to avoid miscarriage, further expansion of the rules of recovery have been permitted to allow recovery for a single injury from multiple manufacturers because of the impossibility of identifying the manufacturer of the specific product that caused the injuries. At least two courts have permitted all manufacturers of DES in the year that the drug was taken by the mother of the injured daughter to be joined as defendants, with any award to be shared based upon the market share each manufacturer had during the year of the mother's pregnancy. The courts adhere to the principle that in this manner the manufacturer can spread the cost of the injury among all of those who benefit from the continued use of a line of products.

The sharp increase in the number of products liability actions involving drugs, vaccines and devices has now reached the point, however, where legislative action is being sought as a means of keeping vital products available for the benefit of society. Of particular concern to obstetricians and gynecologists are developments in the products liability suits involving Bendectin, Dalkon Shield and oral contraceptives. Products liability suits are usually filed against a manufacturer of a product that is alleged to have caused injury, but when drugs and contraceptive devices are the product, physicians may be joined as defendants.

Two massive products liability trials have been of particular interest. In one, a U.S. District Court in Cincinnati faced with 1,200 cases against Merrell Dow Pharmaceutical, Inc. separated the issues of causation and damges. When the jury found that Bendectin was not the cause of alleged birth defects, the cases were disposed of without finding damages for the individual plaintiffs whom the jury was not permitted to see. Since $1 million to $1.5 million for legal costs and expenses for plaintiffs' attorneys are unpaid, an appeal is predicted. Some 18 million American women have taken Bendectin to alleviate morning sickness during pregnancy. Although the drug was removed from the market in 1983, primarily because of the litigation costs, another possible 68,000 cases may be filed in state and federal courts. Merrell had offered a $120 million settlement fund to dispose of all pending and future claims, but this offer was not accepted by plaintiff's attorneys in the Cincinnati case because of the inclusion of future claims.

A. H. Robins Company removed the Dalkon Shield from the market in 1974 at the request of the Federal Food and Drug Administration but by the end of 1984 had settled 8,200 cases out of court for a total of $314.6 million and had established a $615 million legal reserve fund to handle the thousands of lawsuits it still faces. Nearly 3 million Dalkon Shield IUDs were sold in the United States between 1971 and 1974. At least 12,000 suits have been filed.

In June 1984, the Colorado Supreme Court upheld a jury award of $600,000 in compensatory and $6.2 million punitive damages against A. H. Robins Company to a woman who suffered a spontaneous septic abortion caused by a massive infection from the use of a Dalkon Shield manufactured by the company. The woman underwent a total hysterectomy at the age of 24 to save her life. More than a year prior to the plaintiffs' septic abortion the company had been warned of this danger by a consultant and was aware of 22 similar incidents, but failed to warn users of the life-endangering risk.

In another recent decision, Massachusetts' highest court has ruled that manufacturers of birth-control pills have a duty to warn consumers of all the specific side effects that could result from taking the drug. The case was filed against Ortho Pharmaceutical Corporation. The majority ruled that manufacturers of oral contraceptives "warrant the imposition of a common law duty . . . to warn users directly of associated risks." Since women take a more active part in deciding whether or not to take oral contraceptives than they do in taking other prescription drugs, women are entitled to the fullest warnings available, the majority reasoned. The warnings given to a woman by her physician may be inadequate because they occur over a period of years and may be diluted or abandoned with each refill of the prescription, according to the majority. The plaintiff suffered a stroke age 26 after taking the oral contraceptive for three years. Although the patient package insert at the time warned of the possibility of "blood clots," it did not mention strokes. Damages of almost $1.6 million were reinstated by the court. The word "stroke" was added to the patient package insert one year after the plaintiff suffered the stroke and a year before the suit was initially filed. The company is seeking a hearing before the full bench of the Massachusetts Supreme Court in an effort to overturn the decision, since the company includes more warnings in the patient package insert than the Federal Food and Drug Administration requires.

All of these developments fashioned by the courts prompted development of a proposed Model Uniform Product Liability Act in 1979. This act is now being proposed for Congress to enact as a single and uniform law that would preempt all state product liability laws. If enacted, however, judicial activism will not diminish, since the language of any statute is given meaning and application by the judiciary and phrases in the act are relatively general and open-ended.

The judiciary has also been creative in the law governing medical professional liability cases. During the first half of this century, liability for negligence was imposed on the medical profession only upon a showing that the defendant had failed to exercise the skill and ability of members of the profession in that or similar localities. Advances in transportation and communications eliminated the justification for the locality rule and the judiciary responded by imposing upon the medical profession the duty to exercise the care and skill of the average qualified practitioner or, in the case of a specialist, the care and skill of a qualified specialist or a national standard.

Expanded theories of informed consent have been developed by the courts as scientific advances have occurred and the public has become more sophisticated in its knowledge of alternative procedures and therapeutic developments. As the medical profession has sought relief from the legislature, it has also been provided with a lesson on how the judiciary gives meaning and application to legislative enactments.

Court decisions have abandoned rules of sovereign immunity, charitable immunity, interspousal immunity and parental immunity. Juries and courts have also abandoned theories of contributory negligence on the part of a plaintiff in medical professional liability cases to bar any recovery and have moved toward comparative negligence theories to reduce but not bar recovery in appropriate cases. Courts have also expanded theories of recovery to permit awards for intentional infliction of severe emotional distress, outrageous conduct and negligent infliction of emotional distress without the necessity of physical injury. The imposition of liability for failure to warn a person who is injured or killed by a patient when the physician knew that the patient presented a serious danger to the individual victim is yet another example.

Wrongful Life, Wrongful Birth and Wrongful Conception

With advances in technology, the number and theories of birth-related claims have increased. Certain chromosomal disorders and approximately 50 inherited diseases associated with enzyme deficiencies constituting between three and five percent of all known birth defects can be diagnosed prenatally. Amniocentesis can identify various genetic defects and chromosomal anomalies as well as the sex and blood type of the fetus. Genetic testing services are becoming available to a larger segment of the population and improved techniques and advances in scientific knowledge are expanding their efficacy and application.

Coupled with the advances in technology are developments in the law that give the pregnant woman a constitutionally protected right of privacy to terminate a pregnancy up to the sixteenth week at least. With the availability of genetic counseling, the courts have not had difficulty in recognizing that a physician has a duty not only to the pregnant patient, but also to the unborn child. Two types of plaintiffs have used "wrongful life" as a cause of action: planned but defective children and illegitimate but healthy children. The child in these cases seeks recovery for the injury suffered as a consequence of birth as a flawed or stigmatized child. The cases are based on the contention that but for the physician's negligence in the diagnosis or treatment of the mother, the child would not have been born.

With the exception of four jurisdictions, the courts that have considered "wrongful life" cases have used one or more of the following grounds not to recognize a cause of action: the law is not competent to resolve the issue of whether a defective life is better than no life at all; the infant suffered no legally cognizable injury; calculation of damages based on the difference between a flawed life and no life at all is impossible; and the action is contrary to public policy.

"Wrongful life" cases do not allege that the physician's negligence was the cause of the child's defects, but rather that the physician's negligence in diagnosis of rubella or in genetic counseling was the cause of the child's defective existence. Proof of proximate cause is satisfied by a demonstration that the child's mother would not have conceived or would have aborted the unborn child if the physician had not been negligent by failure to diagnose a condition that would harm the fetus, failure to utilize genetic testing services or in genetic counseling.

California, Connecticut, New Jersey and Washington have recognized the cause of action and have awarded damages to the extent of paying for a defective infant's extraordinary medical expenses either to the infant or to the parents. In the New Jersey case, the parents were barred from recovery of damages for their emotional distress and the extraordinary medical expenses by the statute of limitations. California recognizes the cause of action only for the infant and not the parents.

Whether the California, Connecticut, New Jersey and Washington cases presage a new trend in recovery remains to be seen. The majority of jurisdictions allow recovery to the parents in these cases under a "wrongful birth" cause of action reasoning that to allow recovery to the defective child is inconsistent with traditional tort theories. The tort system is designed to afford a remedy to an injured party that will place the party in the position he or she would have been but for the defendant's negligence In "wrongful life" cases, the plaintiff would never have been born if the defendant had not been negligent. Thus, the courts have found it logically impossible to measure the damages since it is the difference in value between nonexistence and existence in an impaired state.

"Wrongful birth" suits are brought by parents of defective newborns against physicians and the cause of action is recognized by the courts in all of the jurisdictions where suits have been filed. The decided cases involve failure to diagnose or advise of the effects of ruebella during the first trimester to the pregnant patient; failure to diagnose pregnancy promptly enough to permit elective abortion to avoid the birth of a defective newborn; negligence in the performance of an abortion; and negligence in genetic counseling.

Although the cause of action for "wrongful birth" is well recognized, there is great disparity in the damages awarded by the courts of the various jurisdictions. Some recognize damages for emotional distress and some do not. Most award damages for the medical expenses involved in the birth, loss of income if the pregnant woman was employed and loss of consortium. Four awarded expenses directly related to the costs of extraordinary medical expenses for the defective child. Since some of these cases involve children who may have a normal life expectancy and high costs for special needs during that lifetime, some courts have included awards for extraordinary costs that do not terminate with the majority of the defective child. The trend is to seek child-rearing costs in addition to the extraordinary costs to meet the special needs of the defective child.

The "wrongful conception" cases are brought against a physician by the parents of healthy newborns to recover for the physical and financial injury resulting from an improperly or negligently performed sterilization procedure. The unplanned birth of the child is the principal injury claimed. The courts, following public policy in these cases, recognize that there is a fundamental right not to procreate and that when that right has been violated, the law will provide a remedy.

Controversy continues to surround the question of what damages may be recovered for the birth of a healthy child. Older decisions reason that it is not within the province of the courts to decide that the existence of life is a wrong for which damages may be recovered and that birth of a healthy child, even if unplanned, cannot be considered an injury. The problem of computing damages has become even more confused as courts in different jurisdictions reach different conclusions. Most courts take the position that the burden of an unplanned, healthy child should be offset by the benefits the parents receive from the love and affection of the child.

More conservative courts allow damages for the expenses and difficulty experienced incident to the unexpected pregnancy, but do not allow recovery of the costs associated with rearing an unplanned child on the ground that this would constitute a windfall to the parents while imposing an excessive burden on the physician. One court even went so far as to suggest that if the parents were permitted to keep their child and shift the entire cost of upbringing to the physician who failed to sterilize the mother, that this would create a new category of surrogate parent. A more radical approach has been taken by two appellate courts in awarding unplanned costs of bringing up the child, but they were reversed by the states' highest court.

Wrongful conception cases have relied upon one of three theories in seeking recovery. Negligence may be alleged for improper performance of the sterilization operation or for postoperative failure to ascertain whether the operation was successful. In tubal ligation cases, the possibility that the pregnancy and birth are a result of the recanalization of the patient's fallopian tubes exists and must be overcome. Breach of warranty theories have also been used alleging that the physician represented that the sterilization would be irreversible or that it would be one hundred percent successful. This theory has been rejected where the patient cannot prove that the warranty was made and that the patient relied upon the warranty or paid a consideration for the warranty separate from the physician's fee for the performance of the sterilization. Lack of informed consent has also been alleged contending that the patient was not informed that the sterilization procedure was not absolutely foolproof in preventing pregnancy.

Brain-Damaged Baby Cases

The brain-damaged baby cases carry particularly high awards, frequently in excess of one million dollars. Juries apparently tend to consider full or substantial life expectancy in awarding damages, and causation is often ignored by juries in attempting to provide compensation to take care of the needs of the child.

Possibly related to the brain-damaged baby suits is the increasing number of Caesarean sections being performed in the United States. In 1983, the most recent year for which figures are available, one out of every five newborns was delivered by Caesarean (a national average of 21%). The 1983 C-section rate in the United States was four times higher than a generation ago. The U.S. national average of 21% is comparable to the C-section rates in Canada and the European countries and is well below the 80% rate for wealthy patients in some South American countries. The average C-section rate in Florida is currently 30%.

Several explanations are given for the increased rate of C-sections. One is that the surgical procedure is safer than formerly. The explanation is buttressed by statistics indicating that the rate started climbing in the early 1960s as the operation and postoperative care became safer. The safety of the surgical procedure has improved enough that physicians do not hestitate to perform a C-section if there is any possibility that it will improve the outcome. Some physicians express the belief that the threat of professional liability suits has contributed to the rising C-section rate. Another contributing factor may be that vaginal delivery following a C-section is considered safe today because of the new surgical techniques for the sections. Whatever the primary reason, it is apparent from closed claims studies that physicians rarely are sued for performing a C-section, while failure to perform one may be alleged in a brain-damaged baby case.

Claims Study Involving Infants with Neurologic Deficit

In 1982, the Physician Insurers Association of America created a special committee to study claims involving neurologic deficit in the newborn. The committee, comprised of representatives of 15 member companies with the support and encouragement of ACOG, prepared detailed analyses for 295 cases and published an Interim Report in 1984. The purpose of the study was to identify for practicing physicians certain areas that might assist them in reducing exposure to liability and enhancing patient safety.

The data analyzed came from the following ten states: Alabama, Arizona, California, Florida, Illinois, Michigan, New Jersey, New York, North Carolina, Pennsylvania and the District of Columbia. The attending physicians were predominantly graduates of American schools (70%) and specialists board-certified in obstetrics and gynecology (75%). Solo practitioners were involved in 42% of the cases and a partnership or group practice in 51%. There were no discernable patterns involving the number of hospital beds or hospital deliveries. While only 26% of the hospitals had a medical school affiliation and only 27% a residency program in obstetrics and gynecology, the committee concluded that the differential was mainly attributable to the fact that many physicians at teaching institutions would not be insured by the companies in the study.

The following observations and suggestions were offered in the Interim Report:

1. Record Keeping Is Inadequate. The committee found that there was insufficient documentation of patient history in the antepartum record. The description and timing of significant events before and during the labor process were found incomplete at best; infant records were found to be sketchy and of little help in establishing the infant's condition postpartum or in defending a claim that neurologic problems were due to birth trauma. The committee suggested that physicians and nurses be urged to improve record keeping in these vital areas in the interests of good patient care and more defensible medical-legal positions.

2. Timely Identification and Management of High-Risk Patients are of Particular Concern. The committee found the problems to involve identification of risk factors, underemployment of antenatal screening and inadequate consultation. The committee emphasized that it is important to identify, document and monitor the high-risk patient throughout the pregnancy with consultation and referral to tertiary centers where appropriate.

3. Dysmaturity Was Noted To Be a Significant Problem and the Committee Urges the Use of All Available Modalities to Confirm the Presence of Prematurity and Postmaturity. Ultrasonography was used in 32% of all cases: more specifically, it was used in 23% of the cases to establish fetal age. However, in several cases, it was not done early enough to be of value (prior to the 30th week of gestation) and in other cases there was no follow-up sonography, when indicated. The committee suggested that ultrasound is one important method to be employed in cases where there is doubt about gestational age. However, the committee noted that clinical evaluation is always essential.

4. Problems of Communication are Evident Among Partners in Group Practice, Consultants and Covering Physicians. Doctors are Urged to Carefully Coordinate Patient Care with Their Associates in Practice, with Consultants and Covering Physicians.

5. There are also serious communication problems between obstetricians and pediatricians, the committee found, resulting in the absence of the pediatrician in the delivery room in complicated cases. Pediatricians should be notified in such cases, and their early and continued involvement should be encouraged. Further, timely follow-up reports from pediatricians to obstetricians on the condition of the infant are most important.

6. The committee observed that the belated arrival of a physician during the labor process increases liability exposure whether or not the reasons for delay were valid. Accordingly, the committee urges physicians to be responsive to nurses' reports about the patient's condition and to be prepared to be in attendance or provide for immediate coverage.

7. The use of fetal monitoring and the interpretation of tapes are key factors in any case involving fetal stress. The data reviewed by the committee seems to indicate inadequate use of internal fetal monitors. Of the 295 cases studied, external monitoring was done in 150 cases (50.8%) while internal monitoring was done in 67 cases (22.7%).

The committee feels that electronic fetal monitoring is of great value during labor and particularly urges the use of internal monitoring when indicated. Personnel competent to read tapes must be available at all times.

The committee noted that the defense of some cases has been prejudiced because the complete monitoring tapes were not retained. The committee believes that physicians and hospitals should be alerted to the need to retain the entire tape as a part of the patient's record.

8. The committee found that claims are replete with allegations of delay; delay in appreciating and responding to evidence of fetal stress; delay in arriving at a decision to do a Caesarean section; and delay in performing the Caesarean after the decision has been made. The committee found that these delays are matters of concern and that physicians should carefully evaluate their procedures in these vital areas.

9. The committee observed, with dismay, that in many cases subsequent treating pediatricians have ascribed an infant's neurologic problems to "hypoxia during the birth process" or "birth trauma" without having conducted any investigation and, therefore, without any medical justification whatever. The committee warned that such careless statements can make the defense of a case extremely difficult. The committee did not suggest that a scientifically determined diagnosis should be withheld, but rather suggested that pediatricians should be judicious and refrain from making "loose statement without foundation."

Analysis of Neonatal Brain Damage Claims of the Farmers Insurance Group

In the February 1984 issue of **The Western Journal of Medicine,** Marvin Cornblath, M.D. and Russell L. Clark, LL.B., published the results of a retrospective analysis of the records of 250 infants with claims of alleged "brain damage." The births occurred between 1957 and 1982 in five states and were in the files of the Farmers Insurance Group between October 1980 and January 1983. The records included settled, active and potential claims as well as several claims that had been dropped. Of the 250 infants, 80 were born before 1976, 122 from 1976 through 1979 and 48 since 1979. The records reviewed included prenatal obstetric office records; hospital labor, delivery and neonatal records; birth certificates; previously submitted experts' opinion; and investigative reports generated in conjunction with the insurance claims prepared by claims investigators. The information varied both in quality and quantity because the births occurred in a large variety of hospitals including both community and university teaching hospitals. The data available was abstracted and the frequency of each of 27 risk factors was determined and compared with the expected frequency based on data from two large general populations of live births.

The classification of preventable risk factors included actions or inactions taken by the mother, parents, obstetrician, family physician, midwife, anesthesiologist, nurses or pediatrician that clearly contributed to the neonatal course and outcome of the affected infant. Examples included the mother or parents refusing consent for timely Caesarean section; misapplication of mid or high forceps resulting in skull fractures and aural hemorrhages; pronouncing infants dead who later were revived and survived; inadequate treatment of infection in one twin but not in the other; and inexpert ventilatory management inducing bilateral pneumothoraces.

The nonpreventable included cases in which the untoward outcome or clinical course could not have resulted from any specific action or inaction taken during the perinatal period and conditions for which no known prevention or treatment is or was available at the time of the birth. Examples included late onset of abnormal neurologic behavior following a completely uneventful pregnancy, labor, delivery and neonatal course; congenital anomalies; unavoidable, noninduced prematurity or extremely low birth weights in both average-size-for-gestational-age and small-size-for-gestational-age infants; complicated pregnancies associated with difficult conceptions, early bleeding and multiple infections, often viral; unexplained catastrophic events occurring during labor or delivery; and nonpreventable congenital or perinatal infections such as rubella, cytomegalovirus or herpes.

Indeterminate included those cases that contained insufficient information, multiple factors or conflicting reports that made it impossible to determine which events were associated with or responsible for the outcome. Examples included events related to pregnancy, labor and delivery were unrelated to outcome, but no record or report of care from the neonatal intensive care unit was available; multiple injuries claimed, but examination at age 3 or 4 years showed no significant abnormalities; poor pregnancy history, complicated delivery, multiple congenital anomalies and an intrapartum maternal death; conflicts among the delivery record, the nursery record and the intensive care records relating to critical events during labor, delivery, Apgar scores, nursery course, and the like; and claims that certain equipment, staff, operating rooms or physicians were or were not available and in attendance at the time of delivery.

After all of the claims were classified, the frequency of each risk factor was compared between the preventable and nonpreventable groups to determine the specificity, predictability and relative risk of each factor. Of 24 objective high-risk factors associated with poor pregnancy outcome, 20 were significantly increased in the study group. Those with the highest risk ratios included maternal obesity, diabetes, bleeding, twins, breech presentations, prematurity (less than 35 weeks gestation), postmaturity (42 weeks or more), prolapsed cord, low one- and five-minute Apgar scores, birth weights 2.26 kg or less or more than 4.5 kg. Of the 250 claims, 77 or 31% were classified as preventable, 105 or 42% as nonpreventable and 68 or 27% were indeterminate.

Odds ratios were also calculated for each of the risk factors with 13 differing significantly between the cases reviewed and the general population of live births. These included prolonged gestation, Caesarean birth, meconium staining, use of mid or high forceps, persistently low Apgar scores, high birth weight, poor muscle tone and seizures. Only 4 of the 13 high-risk characteristics could be determined before birth and thus lead to an intervention.

The report concluded with the following eight recommendations that might reduce the frequency of neonatal brain damage claims and liability: (1) avoidance of prolonged gestation by precise dating of the last menstrual period, if possible, and the use of ultrasound, stress tests and tests of fetal maturity to determine the optimal time of delivery; (2) precise definition of the indications for use of mid or high forceps and limit use to experienced physicians; (3) early discussion with the family and consultations before or early in labor to avoid undue delays in performance of Caesareans; (4) careful evaluation of a mother's risk factors and transfer to hospitals with neonatal intensive care units before the onset of labor; (5) early detailed discussions with all concerned parties to avoid family pressures that prevent or interfere with sound medical practice; (6) careful charting of meconium staining, head-chest circumference, organomegaly and other stigmata of congenital infections or malfunctions; (7) review of the maternal medical history and pregnancy records, use of ultrasound, TORCH titers, immunoglobulin M values, cultures and other diagnostic criteria to establish an etiologic diagnosis that may be related to congenital or familial factors; and (8) before establishing a final diagnosis in "late onset" neurologic abnormalities, review carefully all of the records of the pregnancy, labor and delivery, the complete family and genetic history and investigate postneonatal events such as infections or trauma.

In May, a second report based upon 500 claims may be released. The need for precise, recorded documentation of the family history, genetic history and specific details related to a mother's prior medical history, previous and current pregnancies, labor and deliveries is recommended for all hospitals in both reports as essential for assessing any claim of neonatal "brain damage" attributed to alleged negligence.

NIH Study of Prenatal and Perinatal Factors Associated with Brain Disorders

On April 8, 1985, the National Institute of Child Health and Human Development and the National Institute of Neurological and Communicative Disorders and Stroke released a 450-page report on a year-long study by medical experts to identify pregnancy and birth-related events that may account for neurologic handicap in infants and children. The panel examined data accumulated from the Neurological Collaborative Perinatal Project initiated by the National Institutes of Health in 1959. The NCPP enrolled 55,000 pregnant women in the study and carefully documented prenatal and perinatal (from 20 weeks gestation to the 28th day of neonatal life) events as they occurred. Following the children of these women to age seven years, the Project provided much information linking the prenatal and perinatal histories of these infants to their later neurologic development.

The preface of the report released April 8 states that in the United States mental retardation affects 850,000 children and cerebral palsy afflicts another 750,000 young people. Handicapped children constitute nearly 10 percent of all school-age children. The neurologic and communicative disorders that affect 42 million Americans cost society $114 billion each year. The panel of medical experts noted that not too long ago, physicians blamed physical birth trauma, such as prolonged labor, abnormal position of the fetus during delivery, and injury from obstetric forceps, for the incidence of several neurologic disorders among infants and children. Advances in obstetric practice, such as the increased use of Caesarean delivery for some breech and low-birth-weight babies, the decreased use of obstetric forceps and steroid hormone therapy for newborn respiratory problems, have nearly eliminated physical birth trauma as a cause of neurologic disabilities.

In the report, the group of medical experts sought to establish risk for later neurologic handicaps among infants who experienced problems during labor and delivery. The panel asked, for example, if it is possible to estimate that an infant who had perinatal problems has a 10, 30, or 50 percent greater chance of developing a neurologic handicap than does an infant who did not have the problems.

The report concludes that premature birth appears to be the most important risk factor for cerebral palsy. Problems associated with prematurity, such as lack of oxygen, respiratory problems and brain hemorrhage, may place infants at high risk for cerebral palsy. Reduced oxygen supply to the fetus that may occur during abnormal labor and delivery is a strong risk factor only among infants who later are quadriplegic and severely mentally retarded.

The report also concludes that pregnancy and birth-related risk factors for epilepsy cannot yet be established. However, newborn infants who show evidence of brain injury in the form of seizures or later cerebral palsy are at a very high risk of developing epilepsy. Epilepsy is one of several problems that results from neurologic damage, but pre- or perinatal risk factors have not been established for epilepsy alone. The condition occurs frequently in children with other neurologic disabilities, such as cerebral palsy or mental retardation.

Because risk estimates are merely probabilities, the medical experts who prepared the report also looked for frank causes of neurologic dysfunction. However, puzzling differences among individual infants complicate the task of establishing the cause of pregnancy and birth-related brain disorders. Few infants who experience difficult labor and birth develop later neurologic handicaps. The report found that most infants who experience these difficulties develop normally.

The report notes that although it once seemed simple to say that a specific event, such as birth trauma or hypoxia, was the cause of brain disorders, information in the report shows that it is nearly impossible to pinpoint a single cause and its effect. These events, either alone or together, can cause brain damage, but they by themselves, for example, are not frequent causes of mental retardation. The causes of mental retardation, according to the report, seem to have genetic or biochemical roots not related to birth events.

Hypoxia, including both the inability of the infant to breathe and reduced oxygen supply to the brain, according to the report, has become an apparent cause of cerebral palsy and its accompanying mental retardation. Major challenges now lie in detecting hypoxia early and knowing its duration. While low 10- or 15- minute Apgar scores place infants at high risk for both cerebral palsy and mental retardation, only one-half of the infants with low scores ever develop neurologic abnormalities. Conversely, results from one study reviewed in preparation of the report showed that 73 percent of infants who later developed cerebral palsy had normal Apgar scores.

In attempting to establish both risk and casual factors for pregnancy and birth-related neurologic disorders, the medical experts who wrote the report identified gaps in knowledge and recommended prevention strategies as well as directions for future research. While the prevalence of children with varying combination of mental retardation, cerebral palsy and epilepsy is low, this small group is marked by a high level of disability and a great need for services. Efforts to reduce the incidence of premature and low-birth-weight infants, and to recognize, prevent and intervene before an infant suffers severe or prolonged lack of oxygen could greatly reduce the burden these events impose on the children, their families and society, the report concluded.

The availability of this NIH report to defense counsel should be of some assistance in preparation of the defense of the brain-damaged baby cases. ACOG representatives and the members of the Committee on Professional Liability believe that the conclusions of the report and the materials and studies included in the full report have the potential of slowing the trends in seven-figure dollar awards in these cases.

Special High-Risk Consequences of Interaction with Other Health Care Providers

ACOG has pointed to several types of interactions between obstetricians and other physicians and nurse midwives that may contribute to the brain-damage baby suits. By the very nature of their practice, obstetricians may be called in for the delivery of a high-risk pregnancy because of the failure of a family or other practitioner to recognize the fact that the patient is a high-risk pregnancy. The same situation may arise if a nurse midwife or nurse practitioner provides the prenatal care without consultation with the obstetrician. Another example is the entry on the medical record by pediatricians and/or neonatologists attributing difficulties in the newborn to perinatal problems encountered by the obstetrician. This example was also one of the points made in the PIAA Report on Neurological Deficits of the Newborn.

Educational Liability Claims Against Residency Program Directors in Obstetrics

In January 1985, an ACOG Council surveyed Ob/Gyn residency program directors to determine the frequency and severity of the "educational" liability problem and to alert them to the possibility of lack of adequate insurance coverage. The two examples cited in the survey were:

Case #1

A first-year resident is working with a private attending physician on a high-risk obstetric patient. A serious problem arises with the delivery and there is a bad fetal outcome. The private physician, the resident and the hospital are sued for malpractice. In addition, you are named in the suit for not having rules in your program which forbid a first-year resident to be involved in the care of high-risk obstetric patients.

Case #2

A resident finishes a residency in your program and goes into private practice in an adjoining state. At residency completion you certified the resident as competent for the purpose of taking the written Board examination. After a year in practice the physician is involved in a professional liability action. In addition, you are named as a defendant for allowing an alleged incompetent physician to graduate from your program and for certifying the physician's competence.

A total of 225 programs responded to the survey with 160 reporting satisfactory coverage in both of the cases used as examples. Thirty-four respondents were unable to obtain a satisfactory answer about their coverage. Sixteen respondents reported that coverage was available for the Case 1 example but not for Case 2; and 15 reported no coverage for either Case 1 or Case 2.

The respondents were also asked about suits involving the program director. Eleven such suits were reported with five being similar to the Case 2 example. Two additional program directors were involved in cases with a bad outcome and their in-training evaluations showed a variety of problems that prompted the attorneys to name the program director in the suit as well as the former resident. In two suits, the resident who had completed training sued the program director alleging in one that an inadequate education had been provided and in the other that a derogatory recommendation had been furnished. In another suit reported in response to the survey, a resident in training was named as a defendant and the program director was charged with having inadequate rules. No respondent reported that a judgment had been awarded against the program director, but some of the cases are still in litigation.

Of the programs responding, 80 were in university hospitals; 106 in university-affiliated hospitals; 26 in nonaffiliated hospitals and 13 in government hospitals. The 13 military programs responded that the coverage question was not applicable. The "educational" liability claims are considered by ACOG's Council on Resident Education in Obstetrics and Gynecology as a liberal expansion of tort law that may place an obstetrician in the position of defending a suit for acts that were not known to be actionable. Even if the theories relied upon in such suits do not have merit, defense costs may be high, according to the ACOG Council.

Economic and Emotional Cost of Litigation Process

The current system of tort litigation forces a physician who is named as a defendant to spend substantial periods of time away from his practice. This results in a significant income loss to the practice, while other costs remain constant or increase, ACOG notes. This is one of the particular professional liability concerns of obstetricians and gynecologists. Coupled with the income loss to a practice is the emotional cost to a physician once he or she is named as a defendant in a professional liability action.

ACOG cites the reported studies conducted by Sara Charles, M.D. through surveys of Chicago-area physicians to examine the impact of professional liability litigation on the medical profession. Doctor Charles reported that physicians experience increased anger, indecisiveness, inability to concentrate and "loss of nerve" once sued. She reported that the emotional strain can give rise to anxiety and symptoms such as insomnia, depressed mood, loss of energy, somatic complaints, lack of concentration, irritability, indecisiveness and loss of confidence. In addition, the manner of practice may change because more diagnostic tests may be ordered. Doctor Charles believes that more research is needed to document the impact on the physician-patient relationship and patient care once a physician has been sued.

Other Concerns of Obstetricians and Gynecologists

ACOG notes that the development of DRGs may encourage obstetricians and other physicians to subordinate their clinical judgment to economic considerations. At the same time, a physician knows that compliance with DRG will not provide a complete defense in a medical professional liability case. Plaintiff attorneys and the courts can be predicted to continue to require physicians to adhere to medical standards of care irrespective of DRG and other cost-containment measures.

ACOG also sees every "Baby Doe" as a potential wrongful life or wrongful birth case for the obstetrician that delivered the child. Obstetricians may be inclined to order every genetic test possible to rule out all genetic problems that can be identified. The cost would be enormous, however.

Another concern noted by ACOG relates to the increasing litigiousness of Americans coupled with the trend in advertising by professional expert witnesses and medicolegal consulting firms. These signs portend a situation that will worsen the problems of obstetricians in terms of increasing numbers of professional liability suits with increased costs for defense.

Possible Solutions

ACOG continues to search for solutions to the problems facing obstetricians and gynecologists in the current professional liability climate. The possibility of federal insurance to cover the life-time costs of the severely defective newborns is one that may merit exploration. If federal insurance to cover the extraordinary living and medical needs of the permanent disability suffered by a brain-damaged baby could be made available, professional liability insurance coverage should be affordable and available to obstetricians. This would also assure the availability of obstetricians to handle pregnancies and deliveries in all parts of the country.

ACOG also continues to develop risk-prevention materials for use by educational programs for obstetricians and gynecologists both at the graduate and continuing education levels. Of immediate concern, of course, is the development of information for its members on the availability of insurance coverage and the underwriting standards being employed in every state. This information is being collected to assist members who were formerly covered by its group program as well as others who are experiencing difficulty in obtaining coverage at affordable costs.

FLORIDA MEDICAL ASSOCIATION

History of the Florida Problem

1929-1952

In 1929, the FMA established a group malpractice insurance program with a master policy issued by three major commercial insurance companies. The group issued certificates of insurance to individual physicians. The records of the program do not indicate any specific problems but reveal a low utilization of the program due to the ready availability of insurance carriers marketing professional liability coverage in Florida. There were no unusual activities experienced by the group program until after World War II. At that time, all three companies declined to continue the program by underwriting FMA members. Coverage remained readily available on an individual basis for FMA members, however.

1953-1962

In 1952, FMA established a special committee to review the professional liability problem that had developed in New York State and California and appeared to be beginning in the State of Florida. The committee developed and recommended to FMA a master professional liability program involving centralized claims handling, coordinated legal defense and peer underwriting and claims review by county medical societies. The master program was adopted and for ten years FMA attempted without success to market the program.

1963-1972

In 1963, the London Agency of Atlanta was successful in obtaining the Employers Group of Insurance Companies of Boston to underwrite the FMA group program based upon criteria adopted by FMA. The program experienced very slow growth until the late 1960's when a number of commercial carriers discontinued writing professional liability insurance in Florida.

The Commercial Union of England purchased the Employers Group of Insurance Companies in 1972 and directed termination of all physician's medical liability insurance in the United States at year's end including the FMA program.

1973-1975

In cooperation with the London Agency, FMA had compiled good statistical data regarding the group program terminated in 1972. Armed with the data, a representative of FMA and the London Agency explored the American market for a major insurance company to underwrite the FMA group program effective January 1, 1973. Three major companies agreed to underwrite the program: Chubb and Son of New Jersey, Continental of North America and Argonaut Insurance Company of California. The Argonaut Insurance Company was selected to underwrite the program because it agreed to quarterly payment of premiums. This was later changed to semiannual premium payments. The program insured almost 7,000 physicians or an estimated 85% of the potential market.

In early 1975, attorneys for the Teledyne Corporation, representing their subsidiary the Argonaut Insurance Company demanded major changes in the premium structure for the FMA program that differed from the provisions in the contract executed in December 1974. A 300% increase in premiums was demanded and an assessment against every physician insured in Florida for an amount totaling in excess of $13 million. FMA contended the attempted increase was illegal and a lengthy, costly trial ensued with a U.S. District Court in Jacksonville ruling in the summer of 1975 that the contract between FMA and Argonaut Insurance Company could not be enforced because of the annual determination of rates. The Court did order Argonaut to honor the premiums and contract for the year 1975 and required Argonaut to refund the illegally assessed additional premium. Argonaut discontinued writing professional liability insurance in Florida at the end of 1975 and also terminated the Florida Hospital Association group program that insured more than 30 hospitals.

1975-1981

FMA and the London Agency searched the entire American market and were unable to locate a reputable commercial carrier to underwrite the FMA group program effective January 1, 1976. FMA leadership was faced with three options: (1) to do nothing and allow the Florida Legislature to attempt to resolve the crisis; (2) solicit funds from individual physicians to capitalize an insurance company; or (3) utilize a Florida Statute that allowed the formation of a Trust with unlimited liability but limited application; i.e., professional liability indemnification. FMA pursued the third option and in cooperation with the London Agency formed the FMA Professional Liability Insurance Trust that began issuing coverage on December 1, 1975.

The Trust issued claims-made coverage allowing approximately one-third of the premiums to be utilized for surplus. Toward the end of 1976, this surplus was released by each individual physician from his trust account and the Florida Physicians' Insurance Reciprocal was capitalized. The Reciprocal assumed all assets and liabilities of the Trust with insurance coverage for any future losses.

The Reciprocal was required to go to Lloyds of London and other underwriters to obtain needed reinsurance coverage since there was no major reinsurance facility available in the United States. The reinsurers imposed conditions to assure the stability of the Board and management of the Reciprocal resulting in FMA and the Trust making arrangements for the dissolution of Harlan-Med, Inc., an insurance agency owned by FMA, and the utilization of the assets to form the Professional Insurance Management Company (PIMCO) as the managing agent for the Reciprocal and general insurance agency for other FMA-sponsored insurance programs. Originally, FMA owned 50% of PIMCO stock that was sold to the Reciprocal shortly after the program was stabilized.

Premiums in Florida for the years 1963-1985 are shown in Table IV in Appendix B. Direct premiums written in Florida for 1975 through 1984 are shown in Table III, Appendix B. Tables I and II in Appendix B show numbers of claims and payouts in Florida for the years 1975 through 1983.

1975 Legislative Actions

In an attempt to resolve the professional liability crisis, the Florida Legislature adopted two major programs in 1975; namely, the Patient's Compensation Fund (PCF) and the Joint Underwriting Association (JUA). The medical malpractice JUA consisted of all private companies licensed to issue casualty insurance in Florida and its purpose was to provide coverage for claims arising out of the provision or failure to provide medical care or services and coverage for bodily injury or property damage to the person or property of any patient arising out of a Health Care Facility insured under the program. The JUA was initially created for three years and then extended for an additional three years. The legislature made the JUA permanent in the 1981 session.

The Patient's Compensation Fund was created to provide payment for medical malpractice and other specified tort awards in excess of $100,000. The fund was authorized to assess its members for excessive losses. Awards against health care providers who paid the required fee to the PCF were limited to $100,000 per claim or $500,000 per occurrence.

In addition to establishing the JUA and PCF, the Florida Legislature in 1975 and subsequent sessions also enacted the following tort reforms: (1) creation of mediation panels consisting of a physician, a circuit judge and a lawyer to determine whether there was negligence on the part of a physician or hospital, with the decision reached by the panel admissible in evidence if the plaintiff proceeded to go to court; (2) revision of the statute of limitations for medical malpractice claims; (3) elimination of the Ad Damnum Clause; (4) establishment of criteria for informed consent; (5) structured payment of awards when future damages are $200,000 or more; (6) itemized verdicts; (7) definition of similar health care provider; (8) application of collateral sources in jury trials as a direct off-set; (9) elimination of the use of Res Ipsa Loquitor except in cases involving foreign bodies; (10) establishment of a remittitur-additur provision allowing adjustments by the court of certain jury verdicts; and (11) adoption of the recovery-of-costs concept wherein the losing party must pay the attorneys' fees of the prevailing party in a medical professional liability action.

On February 28, 1980, the Florida State Supreme Court declared the pretrial screening panels unconstitutional.

1981-1983 Crisis

Following the decision on the mediation panels, a flood of new cases were seen and insurance premiums continued to escalate. By 1983, the records of the Reciprocal insuring more than 5,000 of the state's physicians showed that an average of one of every four doctors in the state could expect to become involved in a professional liability claim in 1983. The Patient's Compensation Fund was declared inoperative in 1983 due to its inability to pay claims because it was experiencing large losses.

FMA mounted an extensive legislative campaign aimed at correcting the problem and was successsful in having seven reforms passed by the Florida Senate. The Speaker of the House, however, successfully blocked floor consideration of the proposal.

Situation in 1984

At a special called meeting of the FMA House of Delegates early in 1984 five recommendations were unanimously adopted. The recommendations called for placing on the November 1984 ballot an amendment to the Florida consitution calling for summary judgments in civil actions if the court finds no genuine dispute concerning the material facts of the case; limitation of noneconomic damages to $100,000; and elimination of joint and several liability in a civil action. Additional recommendations called for a legislative program to embody the same principles; a mandatory assessment of $300 each to be utilized in implementing the professional liability program; the continued study of "trip" insurance for hospital admissions, "no fault" concepts and the problem of contingency fees; and an educational role for each member in informing the public and constituents about the professional liability problem facing the people of the state.

By the August 1984 deadline, the requisite 630,000 signatures had been collected to place the initiative on the November ballot. The Florida Academy of Trial Lawyers filed a legal challenge to have the initiative removed from the ballot, charging that it violated the Florida Constitution's limitation that initiatives involve only one subject. At the trial level, the trial bar's claims were rejected and the court ruled that the amendment contained only one subject and was not misleading, but rather, "clear and enlightening." The Florida Supreme Court shortly thereafter overturned the trial court and removed the initiative from the November 1984 ballot.

On October 10, 1984, one week after the Supreme Court of Florida ruled, the FMA Board of Governors met to review the professional liability situation in detail. The Board acted to authorize the FMA president to appoint a Blue Ribbon Committee to define and recommend policy for resolving the liability crisis and instructed the president to contact and schedule meetings with the president of the Florida Bar, the governor and the legislative leadership on the professional liability issue. As a result of these actions, the FMA Board of Governors on January 12, 1985, adopted the following motion:

> "That the FMA Board of Governors approve support of solutions for resolving the professional liability crisis that will achieve stability in respect to the current cost of professional liability insurance and will provide to patients who are truly injured in the medical system an oportunity to be adequately and efficiently compensated for their injuries; and further, that the FMA support the following concept as solutions that meet the criteria set out above:

A) Tort Modification Package
   1. Caps on Awards
   2. Structured Settlements
   3. Eliminate Joint or Several Liability, or

B) Alternative Resolution for Malpractice Disputes Through any of the Following, but not Limited to:

1. Modified 'No-fault' or 'Worker Compensation' Approach
2. Arbitration
3. Screening Panels
4. 'Trip Insurance'
5. Other Effective Alternatives that Might be Identified

C) General Solutions that Would be Considered Upon the Approval of the Concepts Contained in Either Category A or B:
1. Strengthening Risk Management Programs
2. Strengthening the Ability of the Board of Medical Examiners to Deal With Incompetent Physicians
3. Consider the Feasibility of Mandatory Insurance for Physicians (This Concept is Linked Specifically to Item A(3) Joint and Several Liability)"

The South Florida Health Care Coalition Task Force on Medical Malpractice

The Coalition is made up of representatives of major businesses and industry in South Florida. In 1984, the Coalition established a task force with representatives of major business and industry throughout Florida as voting members. The task force did invite advisory committee members to work with it throughout its deliberations. In addition to FMA, various hospital associations, the Florida Bar, the Florida Academy of Trial Lawyers and several other groups participated as advisory members. The task force held its first meeting in September 1984 and concluded in January 1985.

The task force voted to propose that the Florida Legislature adopt a bill that would abolish the recovery of legal fees by the prevailing party; install a 90-day cooling-off period prior to the filing of a medical professional liability suit; strengthen the disciplinary powers of the Florida Board of Medical Examiners; provide for a structured payment of awards; strengthen the ability of the Board of Medical Examiners to assure adequate medical training for foreign medical graduates; mandate professional liability insurance coverage for all physicians at $150,000/$450,000; mandate 12 hours of continuing medical education every two years and an additional three hours of continuing education in the area of risk management for licensed practitioners; expand mandatory reporting of disciplinary actions against physicians to include HMOs and ambulatory surgical centers; eliminate joint and several liability; mandate the establishment of internal risk management programs in all hospitals and require that a physician be a member of the institution's risk-management committee; change the standard of proof in medical professional liability actions from "the greater weight of the evidence" to "clear and convincing evidence"; require that medical experts in medical professional liability cases must have been engaged in the practice of the teaching of medicine within the 24 month period preceding the alleged act; and place a limit of $500,000 on noneconomic damages, excluding punitive damages, in any medical professional liability action.

The FMA views a number of recommendations for change made by the task force of major benefit and plans to closely follow the activity of the task force with respect to the introduction and support for its proposal.

The Governor's Task Force on Medical Malpractice

In 1984 following the introduction by Senator Dempsey J. Barron of a no-fault bill to address the professional liability problem, the Florida Legislature created a Task Force on Medical Malpractice, appointed by the governor to examine and identify issues relating to medical professional liability in Florida. The task force was also charged with the development of policy recommendations to address the legal disciplinary, regulatory, financial and market place considerations necessary to assure a cost effective, fair and reasonable system of compensation and justice in Florida. The task force was asked to provide a written report to the governor no later than April 1, 1985.

The task force consisted of 18 members, three of whom were physicians, and was given funding of $200,000. In a report submitted to the governor on April 1, 1985, the task force recommended an arbitration system for the handling of medical professional liability claims. Under the proposed system, there would be a 90-day "cooling off" period before a claim would be filed. This would give counsel for the defense an opportunity to decide whether to admit or deny liability. If liability was admitted, the claim would then go into binding arbitration for the determination of the amount of damages. If liability was denied, the claim would go to nonbidning arbitration and then could proceed to court. Once the case was filed in court, however, there would be penalty if the award was within 25% of the arbitration award in that the award would be reduced by 25% or the percentage difference between the arbitration award and the court award up to the 25%. The task force did not draft legislation to implement its recommendations.

Florida House Subcommittee Professional Liability Package

On April 4, 1985, Representative Art Simon, Chairman of the Florida House Subcommittee on Medical Malpractice, announced the Comprehensive Medical Malpractice Reform Act of 1985. The bill is divided into three parts addressing the prevention, resolution and indemnification of claims for medical malpractice. The first section contains provisions to require stricter licensure requirements for foreign medical school graduates; withholding of a license to practice medicine in Florida to any person who fails the FLEX examination four times; criminal penalties for submission of a false application for a medical license; require continuing medical education as a condition of licensure; expand the Board of Medical Examiners from 11 to 13 members and increase the number of lay members from 1 to 4; mandate review by the Department of Professional Regulation of any licensee who has two or more claims resulting in paid indemnity within a five year period; require hospitals and ambulatory surgical centers to be liable for the negligent acts of members of their medical staffs when committed in the health care facility; require hospitals and ambulatory surgical centers to investigate suspected grounds for discipline and take disciplinary action when good cause is shown with the definition of good cause expanded to include settlements or awards for medical negligence; expand immunity from civil actions for members of governing boards, medical committees, medical review committees and other persons who participate in peer review or disciplinary proceedings; establish licensure requirements for hospital risk managers; impose criminal penalties for false application for hospital staff privileges; impose criminal penalties for falsification of medical records, give the Department of Health and Rehabilitation Service expanded power to oversee hospital risk prevention programs; mandate annual reports to the Department by hospitals and ambulatory surgical centers on risk prevention policies and procedures and all adverse or untoward incidents and remedial actions as a condition of licensure; require licensed facilities to give immediate notification to the Department of any adverse or untoward incident that results in death or serious neurological injury and require the Department to investigate such incidents and issue a public report of the findings within 90 days; require the Department to notify the Department of Professional Regulation when there is a reasonable belief based on the Department's investigation that a health care practitioner committed acts that constitute good cause for disciplinary action; require the Department of HRS to disseminate preventive risk-management bulletins to all licensed health care facilities; require all insurers and self insurers to file annual closed claim reports with the Department of Insurance in greater detail than currently required by law; and require the Department of Insurance in cooperation with the Department of HRS to study the effect of basing medical malpractice insurance premiums on the implementation of exemplary and successful risk-management programs and recommend to the legislature specific changes in premium structures that would encourage effective risk-management programs.

The second section of the bill provides for a redefinition of the standard of care for medical negligence specifically acknowledging changing trends and techniques for the delivery of health care in Florida and the sound discretion that is inherent in the diagnosis, care and treatment of patients by different health care providers; places limitations on experts who must demonstrate active teaching or practice of medicine during the preceding five year period in order to testify; deems good faith failure to order diagnostic tests not actionable; imposes penalties against health care providers who knowingly order, procure, provide or administer excessive or unnecessary diagnostic tests that are not reasonably calculated to assist in arriving at a proper diagnosis and treatment; specifies that signing a medical consent form raises a rebuttable presumption that valid consent was given by the patient; establishes a 90-day presuit screening and settlement period and gives the insurer this 90 days to evaluate the claim with a presuit screening panel or by contract with a state or local professional society medical review committee; authorizes binding arbitration on the amount of damages if the insurer admits liability; specifies that if the insurer makes a settlement offer within the 90 days that is accepted by the plaintiff, attorney's fees are limited to 15% of the settlement amount; specifies that no action for medical malpractice shall be filed unless plaintiff's attorney certifies in good faith that grounds exist for the action and defines good faith to mean that the claimant has received a written opinion from a duly qualified expert that there appears to be evidence of medical negligence; assesses penalties against plaintiff's attorney if the court finds that the suit was not filed in good faith and no justiciable issue was presented against a named defendant; repeals the prevailing party attorney's fee rule; establishes a sliding scale for contingency fees for medical malpractice actions; mandates settlement conferences at least three weeks before trial; subjects awards of general damages to close judicial scrutiny; adds workmen's compensation benefits as a collateral source and sets off collateral sources from verdicts; prohibits pleading punitive damages until the claimant has proper evidence in the record to provide a reasonable basis for recovery of such damages; substantially limits vicarious liability for punitive damages; authorizes structured judgments when future special damages exceed $1 million; modifies the traditional joint and several liability rule and bases recovery on the respective percentages of comparative fault; and authorizes HMO and PPO contracts to provide optional binding arbitration for medical malpractice claims.

The third part of the bill mandates liability insurance as a condition of licensure for all physicians and osteopaths; provides statutory authorization for medical malpractice insurance contracts to contain a clause requiring the insured to cooperate fully in the presuit screening process and to authorize insurance carriers to settle claims without the consent of the insured and mandates a 60-day notice prior to cancellation or nonrenewal of coverage; authorizes insurers to require the insured to be a member in good standing of a duly recognized state or local professional society that maintains a medical review committee; authorizes the Florida JUA to expand the limits of its coverage to $1 million per claim and $3 million annual aggregate; authorizes the JUA to establish a mandatory risk-management program for insureds; and establishes a special risk category in the JUA whereby physicians and osteopaths can obtain liability insurance coverage based on premiums assessed at a fixed rate of 15% of gross income from the delivery of medical services and finances the trust fund through the imposition of a 10% premium surcharge on all medical malpractice liability policies written in Florida.

FMA has suggested changes to this bill that would amend the structured payout provision to make it mandatory for awards in excess of $500,000 rather than permissive structured payout for awards in excess of $1,000,000. FMA is also seeking to revise the section of the bill dealing with the presuit screening period to provide for the defendant to foreclose a claim by offering within 90 days of notice of intent to file a suit to pay the claimants' net economic loss, consisting of medical expenses and wage loss and reasonable attorney fee. FMA would also amend the section on joint and several liability to abolish the use of the doctrine in Florida. Another FMA amendment would delete the section of the bill that makes hospitals specifically liable for negligent actions of medical staff members and would strike the section that mandates professional liability coverage of $1 million/$3 million as a condition of licensure. Another FMA amendment would amend the provision on premiums, with the cap set at $5,000 or 15% of gross income. FMA is concerned that the funding of the program by a surcharge on all malpractice insurance policies with any deficits picked up by the JUA will likely result in an additonal load being added to professional liability policies.

The bill has been reported out of the subcommittee. As it has moved through various legislative committees and hearings, provisions have been deleted and added daily.

FMA continues to work for revision expecting an early mark-up of the bill and final aciton in early May.

Barron Bill

On April 12, 1985, Senator Barron introduced a revised version of his "no fault" bill with preliminary cost estimates indicating a favorable cost impact. The 1985 bill requires a breach of the standard of care in order to trigger payments in accordance with a workers compensation-styled benefit schedule. Hearings on the issue of fault would be held before a judge and payments would then flow automatically from the schedule of benefits to bypass jury trials on the issue of damages. The bill also calls for the court at the request of either party to enter a judgment ordering damages for future losses exceeding $100,000 to be paid by periodic payments.

Other provisions of the bill require all health care providers to be insured as a condition of licensure; provide that all health care to patients shall be deemed to be performed under the laws applying to contracts; provide that in an action for medical negligence the claimant shall have the burden of proof; provide that compensation for disability shall be equal to the claimant's actual lost wages; provide that the health care provider shall furnish to the patient such medically necessary remedial treatment as the patient may require; provide that the court shall use the schedule adopted by the Division of Worker's Compensation as a temporary schedule for determining the degree of permanent impairment; require patients to accept employment suitable to their capacity or be denied any compensation; and provide for a maximum payment of $100,000 in case of the death of a patient. No hearings had been held on the bill in April.

Conclusion

The Committee on Professional Liability will continue to study the professional liability problems facing medicine and plans to report at the 1985 Interim Meeting on the direct and indirect costs of professional liability and other developments.

Appendix A

California

Medical Insurance Exchange of California -		rate increases expected this summer, percentages unknown at this time
$500,000/$1.5 million claims made		
Class 3 (Gyn Surgery Only)	$12,292	
Class 4A & 4B (family practice including Ob and Ob/Gyn surgery)	$21,987	
$1 million/$3 million		
Class 3	$15,868	
Class 4A & 4B	$27,487	
$5 million/$5million		
Class 3	$19,708	
Class 4A &4B	$40,344	

Southern California Physicians Exchange - claims made mature rates

	9/84	1/85	
$500,000/$1.5 million			
Class 7 (Gyn surgery only)	$19,224	$22,368	+15.9%
Class 8A (Ob & Ob/Gyn Surgery)	$24,656	$30,024	+21.8%
$1 million/$3 million			
Class 7	$22,764	$26,616	+16.9%
Class 8A	$29,184	$35,720	+22.4%
$5 million/$5 million			
Class 7	$36,296	$42,808	+17.9%
Class 8A	$46,536	$57,460	+23.5%

Florida

Florida Physician's Insurance Reciprocal - claims made mature rates

	9/84	1/85	
$500,000/$1.5 million (lower rated portions of state)			
Class 4 (Gyn surgery only)	$ 9,455	$14,023	+48.3%
Class 7 (Ob/Gyn Sur)	$23,364	$31,841	+36.4%
Dade and Broward counties			
Class 4	$13,707	$21,035	+53.5%
Class 7	$33,879	$47,807	+41.1%
$1 million/$3 million			
Class 4	$11,819	$18,580	+57.2%
Class 7	$29,205	$42,230	+44.6%
Dade and Broward counties			
Class 4	$17,134	$27,871	+62.7%
Class 7	$42,349	$63,344	+49.6%
$1.5 million/$4.5 million			
Class 4	$13,237	$22,085	+66.9%
Class 7	$32,709	$50,197	+53.5%
Dade and Broward counties			
Class 4	$19,190	$33,130	+72.6%
Class 7	$47,431	$75,296	+58.7%
Rehabilitation Fee on a One Time Basis:			
Class 4	$ 5,000		
Class 7	$ 8,000		

Illinois

Illinois State Medical Inter-Insurance Exchange - mature rates for occurrence coverage.

$100,000/$300,000 for highest of three territories	
Class 6 Ob/Gyn surgery	$13,856
$1 million/$3 million	
Class 6	$32,128
$5 million/$5 million	
Class 6	$43,144

Premiums will increase 7/85

New York

Medical Liability Mutual Insurance Company - 4 territories - mature rates - Occurance

$100,000/$300,000	7/84	4/85 retroactive to 7/84
Territory 03		
Class 3 (Ob/Gyn sur & Gyn only)	$35,415	$54,893
Territory 02	$30,958	$47,985
Territory 01	$27,405	$42,478
Territory 00	$16,021	$24,833
$500,000/$1 million		
Territory 03	$47,811	$74,107
Territory 02	$41,794	$64,781
Territory 01	$36,996	$57,344
Territory 00	$21,629	$33,525
$1 million/$3 million		
Territory 03	$51,704	$80,141
Territory 02	$45,196	$70,054
Territory 01	$40,007	$62,011
Territory 00	$23,394	$36,261

Territory 03 - Nassau and Suffolk counties

Territory 02 - Bronx, Kings, Queens, Richmond, Rockland and Sullivan counties
Territory 01 - New York, Orange, Ulster and Westchester counties
Territory 00 - All other counties

A rate increase of 55%, retroactive to July 1984, has been approved and is shown above.

Texas
Texas Medical Liability Trust - occurrence coverage written for three territories plus a one-time surplus charge payable quarterly over either one year or four years.

$2 million/$3 million 10/84
Territory I (Brazoria, Galveston, Harris, Jefferson, and Montgomery counties)
Class 6A (Gyn Sur only) $22,515
Class 6B (Ob/Gyn Sur) $26,681

Territory II (All other counties except Bexar and San Antonio)
Class 6A $13,293
Class 6B $15,757

Territory III (Bexar county and San Antonio)
Class 6A $16,009
Class 6B $18,282

Surplus Charge
Territory I
Class 6A & 6B $ 8,575
Territory II
Class 6A & 6B $ 5,717
Territory III
Class 6A & 6B $ 7,146

ACOG has also conducted informal surveys of physician-owned professional liability insurance companies since September 1984 to determine if there is a premium differential between coverage for the practice of OB/Gyn surgery and the practice of gynecology only. The following chart illustrates the differential in states charging an excess premium for obstetricians reflecting a typical $1 million policy limit unless otherwise indicated:

State	Percentage Differential
Alabama	19.5%
Alaska	73.6%
Arizona ($100,000/$300,000)	49.1%
California	73.2%
Colorado	26.7%
Connecticut	41.6%
District of Columbia	33.3%
Florida ($500,000 or $1.5 million)	147.1%
Hawaii	108.8%
Idaho	92.4%
Iowa	
a. Between Gyn Minor & Ob/Gyn	318.8%
b. Between Gyn Major & Ob/Gyn	14.3%
Kentucky	19.7%
Louisiana	10.4%
Maine	58.6%
Maryland	111.9%
Massachusetts	35.0%
Minnesota	19.7%
Missouri	27.8%
Nevada	90.0%
New Jersey	
a. Between Gyn Office & Ob/Gyn	277.9%
b. Between Gyn Surgery & Ob/Gyn	11.5%
New Mexico ($100,000/$300,000)	24.8%
North Carolina	39.3%
North Dakota	19.6%
Tennessee	29.3%
Texas	18.5%
Utah	55.9%
Virginia	34.0%
Washington	26.6%
Wisconsin ($200,000/$600,000)	43.6%
Wyoming	25.1%

Appendix B

TABLE I

NUMBER OF CLAIMS FOR MALPRACTICE
(By Year of Closure)

	Total Claims	Total Indemnity (In Thousands)
1975	970	10,364
1976	1,195	8,526
1977	1,351	11,840
1978	1,460	12,504
1979	1,483	12,536
1980	1,615	19,838
1981	2,041	34,038
1982	2,655	71,099
1983	2,539	65,214
TOTAL	15,309	245,960

Source
Florida Department of Insurance closed claim reporting system

TABLE II

NUMBER OF SUITS WITH INDEMNITY AWARDS IN EXCESS OF $100,000
(By Year of Closure)

	Indemnity Awards in Excess of $100,000	Indemnity Awards of $1 Million or More
1975	12	0
1976	10	0
1977	12	0
1978	10	0
1979	12	0
1980	29	0
1981	61	4
1982	115	9
1983	112	12
TOTAL	373	25

Source
Florida Department of Insurance closed claim reporting system

TABLE III

MEDICAL MALPRACTICE DIRECT PREMIUMS WRITTEN IN FLORIDA
(In Thousands of Dollars)

1975	33,960
1976	15,187
1977	27,684
1978	36,357
1979	39,162
1980	35,779
1981	46,553
1982	68,299
1983	175,927
1984	211,112

Sources:
Bureau of Economic and Business Research, University of Florida, **Florida Statistical Abstract,** various years.

Notes:

Data for 1983 were provided by the Florida Department of Insurance. In addition, the department projected the 1984 data.

TABLE IV
PREMIUM HISTORY (1963 - 1985)

The following chart shows the steady increase in the cost of professional liability insurance in Florida.

YEAR	HIGH	LOW
1963 (1)	$ 235	$ 99
1971 (1)	3,723	332
1972 (1)	3,425	383
1973 (2)	4,325(2)	381
1974 (2)	4,974	438
1975 (2)	9,252	902
1975 (3)	8,243	814
1977 (4)	10,988	846
1978 (4)	14,021	848
1979 (4)	13,000	865
1980 (4)	12,806	764
1981 (4)	14,612	763
1982 (4)	18,996	964
1983 (4)	28,256	2,678
1984 (4)	32,879*	2,409*
1985 (4)	47,807*	2,846*

(1) Employers ($100,000/$300,000 Occurrence)
(2) Argonaut Insurance Company ($250,000/$750,000 Occurrence)
(3) FMA PLI Trust ($500,000 claims made)
(4) Florida Physicians' Insurance Reciprocal ($500,000 claims made)

*In addition to the premiums shown, contributions to surplus were required for 1984 premiums of $201 (low) and $2,826 (high). For 1985 premiums, a rehabilitation contribution of $2,000 (low) and $8,000 (high) were required from all insureds.

REPORT OF THE BOARD OF TRUSTEES

Subject: AMA Membership Benefits (Resolution 5, I-84)

Presented by: John J. Coury, Jr., M.D., Chairman

Referred to: Reference Committee F (Jerry L. Hammon, M.D., Chairman)

At the 1984 Interim Meeting, the House of Delegates referred Resolution 5. The resolution asks the AMA to report on all existing membership benefits and to develop an additional benefits package for AMA members only.

It has long been perceived (and, indeed, surveys corroborate) that the intangible benefit of representation is one of the main reasons physicians join the AMA. The AMA offers representation for all physicians in the country before Congress, the courts, and federal regulatory agencies, and keeps the profession up-to-date on health care legislation. In 1984 alone, AMA efforts helped prevent the passage of the following proposed legislation: mandatory Medicare assignment, mandatory DRGs for all physicians, Medicare control of organ transplantation, legalization of heroin, mandated physician validation of DRG diagnoses and procedures.

The AMA further represents physicians in academia, in the media, in the hospital community, intraprofessionally, and to the general public. Activities in these areas include: the establishment of a Special Task Force on Professional Liability and Insurance; a wide array of socioeconomic activities, including the monitoring of social trends in health care and the evaluation of alternative forms of health care delivery; studies and planning related to the future of medicine; ongoing cooperation with the Joint Commission on Accreditation of Hospitals.

Tangible benefits also are available to AMA members, and in accordance with the request stated in Resolution 5, a list of those benefits, and a brief description of each, follow:

- Journal of the American Medical Association (JAMA) - Dues-paying members receive JAMA free of charge as a benefit of membership. JAMA provides authoratative, timely clinical coverage of contemporary medicine on a weekly basis.
- Specialty Journals - Dues-paying members can choose one of nine monthly specialty journals as a benefit of membership. These journals provide up-to-date information on advances and developments in nine specialty areas.
- American Medical News - Dues-paying members also receive, free of charge, **American Medical News** on a weekly basis. This newspaper reports on economic issues, local, national and international political affairs, people, and the Washington environment.
- Scientific and Socioeconomic Publications - The AMA makes available books, pamphlets, and brochures covering scientific subjects, socioeconomic issues, health education, practice management guidance, and legal issues. Members receive a 10 percent discount.
- Members Insurance Plans - The AMA sponsors a portfolio of insurance programs for members and their families. These are group plans and cover excess major medical, accidental death and dismemberment, hospital indemnity, member term life, family term life, disability income protection, office overhead expense plans, and Medicare supplement. They are designed to provide coverage for members' life, health, and income protection needs.
- Members Retirement Plan - The Members Retirement Plan provides a balanced investment program. It offers a Fixed Income Fund, which earns interest at an annual composite rate, and an Equity Fund, which is invested primarily in a diversified portfolio of stocks. The options include professionally managed, tax advantaged retirement income accumulation vehicles for Keogh Plans covering AMA members, their associates, and their employees.
- Audio Medical News - Available twice each month, Audio Medical News provides coverage of nonclinical news in audiocassette form. It brings physicians condensed information on matters such as DRGs, HMOs, PROs, cost containment, and health education. The service is available to AMA members at a 15 percent discount.
- Video Clinics - The AMA Video Clinic Library includes 36 programs, offering two- to six-hour

courses. The courses include color videotapes, study guides, and self-assessment tests, and entitle users to Continuing Medical Education units. AMA members can rent or purchase Video Clinics at discounts ranging from 12 percent to 25 percent.

- Market Area Profiles (MAP) - A recently launched service, MAP will enable physicians to obtain detailed demographic, physician manpower, and hospital data to help in selecting a practice site or in adjusting an existing practice to changing market conditions. MAP is the first planning tool that merges demographic and health resource data to offer a complete picture of practice sites. MAP provides data for any location in the country, either by county, city, zip code, or as a "ring study" around a specific street intersection. A booklet is included that explains how to use the data in decision-making. Members will receive a significant discount on the service.
- Placement Service - The AMA Physicians' Placement Service is a computerized information system which provides doctors seeking new professional situations with details on available practice opportunities nationally. **The Opportunity Placement Register** offers practice listings, along with summary information for each. A **Physician Placement Register** affords doctors the opportunity to distribute their curriculum vitae to hundreds of potential employers. Both registers are published bimonthly. Registration with the Placement Service is free for AMA members.
- Medical Information Network (MINET) - Developed by the AMA and GTE Telenet, MINET is a computerized medical information network designed to give health professionals quick access to current information on drugs, diseases, medical procedures, and socioeconomic and clinical literature. It includes an electronic mailbox option which allows subscribers to communicate with one another. AMA members receive a substantial discount on the one-time subscription fee, use the network free of charge for their first thirty (30) days on the system, and pay a reduced montly minimum rate of $20.
- AMA Library - The library houses a vast collection of references on the clinical, socioeconomic, and political aspects of medicine. In addition to in-person and telephone use of the library's resources, AMA members can obtain free computer document searches, including the first five photocopies.
- Practice Management Workshops - These workshops provide practical, in-depth information on business and financial aspects of medical practice. Topics covered include Starting Your Practice, Marketing Strategies, Partnerships and Group Practices, and Gearing Up for Retirement, among others. AMA members may enroll at a discounted price.
- Practice Management Audiovisual Library - Audiocassette and videocassette courses on a variety of issues related to the business of running a medical practice are available. Courses, which include subjects such as Developing a Marketing Plan, Borrowing Money, and Handling Patient Telephone Calls Effectively, are available to AMA members at a discount.
- Patient Health Information - Health education pamphlets, books, and posters designed to encourage better health practices are available on a wide variety of subjects, and are offered to AMA members for their patients at a 10 percent discount AMA Home Health Library includes seven publications covering a variety of health concerns for patients who may seek information and guidance; AMA members receive discounts for bulk orders. Patient medication instruction sheets are designed to provide physicians with supplementary drug information for distribution to patients in an effort to reduce the risk of improper drug use and to aid in patient compliance.
- Hertz Rental Car Discount - AMA members and staff can rent automobiles from the Hertz Corporation at rates lower than those available to the general public. In the past, program participants were entitled to a 25 percent discount off of published Standard Unlimited Mileage rates. Recently, the program has been modified and simplified utilizing Standard Contract (Flat) Rates. The rental rate for a particular car class is the same at all rental locations, except for the New York area where there is a slight surcharge. Other discounts are in effect on weekly, weekend, Canadian and international rates.
- VISA Premier Card - Available to qualifying AMA members, the VISA Premier card offers high credit lines and an advantageous interest rate. It includes a number of special features, such as $400,000 in travel insurance when tickets are purchased with the card, collision insurance on car rentals effected with the card, guaranteed hotel reservations, and access to a wide network of automatic teller machines.
- Physician Recognition Award - The AMA confers this award to recognize the satisfactory completion of continuing medical education courses and activities. The service is free to AMA members.

The AMA intends to further enhance the value of membership in the organization by developing new benefits and refining existing benefits in order to anticipate and be responsive to members' needs.

The Board of Trustees recommends adoption of this report in lieu of Resolution 5 (I-84).

REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

It is again a pleasure to address the House of Delegates on behalf of the Creighton University School of Medicine.

Significant changes have been made in the administration of the medical school. Dr. Beverley Mead has been appointed Acting Chairman of the Department of Psychiatry and Behavioral Sciences succeeding Dr. Emmet Kenney, Dr. Kenney, who headed the Department at Creighton since 1977, had asked to be relieved of the chairmanship to devote full time to teaching as Associate Professor of Psychiatry. Dr. Mead, Professor of Psychiatry, formerly served as Chairman of Psychiatry and is Associate Dean for Academic Affairs. He will hold both positions until a permanent successor to Dr. Kenney is appointed.

Dr. Walter O'Donohue has been appointed as Chairman of the Department of Medicine. He is a graduate of the Medical College of Virginia where he also served his residency in Medicine and a National Institutes of Health research fellowship in pulmonary and cardiovascular medicine. Dr. O'Donohue joined the Creighton faculty in 1977 and served on the Saint Joseph Hospital Medical Policy Board from 1979 to 1982.

Dr. William Pancoe, Assistant Dean for Student Programs at the University of Wyoming College of Medicine, joined the Creighton School of Medicine on July 1st as Professor of Physiology and Assoicate Dean of Student Affairs. He succeeds Dr. Matthew Severin who is working to establish a program in medical jurisprudence for medical students at Creighton.

Creighton University is deeply appreciative to the past administrators for their outstanding dedication and is confident in the leadership abilities of the new appointees.

On June 3rd, I was appointed by the University's Board of Directors to the position of Vice President for Health Sciences and will also retain the separate position as Dean of the School of Medicine.

Once again the academic qualification of our 1985 freshman class reflect the high academic quality of the University. There are 24 states contributing the 110 student incoming freshman class. There are 13 Nebraska residents and 27 women in the class.

For the third year, the School of Medicine's Summer Student Research Program provided students the opportunity to work directly with faculty researchers, acquainting them with basic and clinical research. Ten of the thirteen participating students were funded with stipends from the medical school and three were funded from outside the University, including a recipient of a $2,000 scholarship from the Nebraska Medical Foundation for a study of the composition of vertebral bone.

In my last report, it was noted that Saint Joseph Hospital had been acquired by American Medical International, Inc. The transition has moved smoothly with AMI continuing to support the academic mission of Creighton University as well as other affiliated programs. The Health Future Foundation, created as a result of the acquisition, has awarded over 2 million dollars in grants to health science research and academic programs at Creighton. As a result, plans have begun for the development of a new Center for Diabetes Research and Treatment, a Cancer Center for excellence, a flow cytometry laboratory, a postdoctoral education program in anti-microbial chemotherapy, the development of a new approach to the non-invasive study of arterial wall elasticity, a study on growth hormone secretions in juvenile rheumatoid arthritis, and others.

Plans are also under way for Creighton University and Saint Joseph Hospital to become a clinical testing site for the Pulsemaker Heart Assist System. We are hoping to have FDA approval of the program by next March.

I extend once again my personal thanks to the House of Delegates for the opportunity to submit this report on activities in the Creighton University School of Medicine.

Respectfully submitted,
Richard L. O'Brien, M.D.
Dean

REPORT OF THE NEBRASKA DEPARTMENT OF HEALTH

In this report, I will highlight five issues which are high on the Department's priority list including the following: LB407 review of credentialing; the administration of the Maternal and Child Health and the Preventive Health Block Grants; AIDS; CMV and Herpes Infections in School Children; and a CDC Grant looking at Pesticide Poisoning.

LB407: On April 15, 1985, the Nebraska Legislature enacted a bill authorizing a credentialing review program in Nebraska. This program, modeled after existing programs in Kansas, Minnesota, and Washington, requires any health professional group seeking initial credentialing (licensure, certification, registration, etc.) or seeking a substantial change in its scope of practice to undergo a review by a technical committee appointed by the Director of Health. The recommendations of the committee, along with those of the Director of Health, are submitted to the Legislature. At present six committees are reviewing eleven credentialing proposals. Four of these represent a potential change in scope of practice, including proposals concerning dental hygiene, chiropractic physiotherapy, dental anesthesia, and optometric therapeutic eyedrops. The other seven propose new credentialing including dietitions and nutritionists, dental assistants, respiratory therapists, social workers, ophthamic dispensers, athletic trainers, and professional counselors. Final reports are expected by early December.

Committee A - Vision Care issues - September 20, 9 a.m.
Committee B - Dental Care issues - September 19, 8:30 a.m.
Committee D - Soc. Workers/Prof. Counselors - September 18, 9 a.m.
Committee D - Physiotherapy/Ath. Trainers - September 17, 9 a.m.
Committee E - Dietitians/Nutritionists - October 1, 9 a.m.
Committee F - Respiratory Therapy - September 30, 9 a.m.

Block Grant Process: A competitive process was established this year to fund special projects from the Maternal and Child Health and Preventive Health Block Grants. Priorities were established as a result of input from the Statewide Health Coordinating Council and the Area Health Advisory Councils, and from comments received from public forums that were held in the

Summer of 1984. Recommendations contained in the State Health Plan and the National Public Health Service's 1990 Objectives for the Nation were also considered. Priorities for the Maternal and Child Health projects included decreasing the incidence of infant mortality and morbidity, assuring access to quality maternal and child health services, and reducing injuries and deaths due to child abuse. Priorities for Preventive Health and Health Services included expanding the availability of preventive health services in medically underserved areas, preventing dental disease in children, and reducing morbidity and mortality through programs dealing with high blood pressure control, accident prevention, smoking control, improved nutrition, physical fitness and exercise, and control of stress and violent or sexually abusive behavior.

A total of 110 concept papers were received and reviewed by two review committees. The Nebraska Medical Association and the Nebraska Academy of Pediatrics were represented on these committees. Ultimately, 20 projects were selected for funding. Approved Maternal and Child Health programs included three prenatal projects in the western part of the state, a prenatal education project, a program dealing with fetal alcohol syndrome, two projects for families involved in child abuse, and a low birth weight risk assessment program. Approved Preventive Health Projects included three sexual assault prevention projects, a center for rural community health promotion, a mobile exhibit on heart risk factors for elementary schools, a teacher preparation for tobacco education project, a program for poison prevention, a life saving skills and safety program, and several projects dealing with wellness or with particular aspects of wellness such as nutrition, stress control, physical fitness and safety.

The total amount of funding awarded for these programs was $531,132. The process this year was a transition process toward making all grantees of block grant funds more competitive and more accountable.

Acquired Immune Deficiency Syndrome (AIDS): Concern about AIDS is increasing nationally as the number of persons affected increases and as persons not associated with the original risk groups are manifesting the disease. To date, approximately 14,000 persons have been diagnosed in the United States, about half of whom have died.

While Nebraska is considered to be a low risk state, the Department feels we must plan for our role in dealing with the disease. We have received a grant from CDC in the amount of $44,000, primarily devoted to testing in the blood banks. To avoid the blood banks being used inappropriately as testing centers for persons who wish to know if they have been exposed to the HTLV III virus, alternate sites have been established. Testing thus far in the alternate sites has been primarily from Lincoln and Omaha. Statewide, 125 persons have been tested. The Department is collecting data from these sites to determine the positivity rates. The sites are referring persistently positive to private physicians or to the UNMC Viral Syndrome Clinic for clinical evaluation. Attention is drawn to the fact that the diagnosis of AIDS rests on clincial criteria, and that blood tests do not form the basis for the diagnosis. Except for its role in protecting the blood supply, the implications of a positive test for HTLV III antibody is not yet known.

In addition to the activities carried out through the CDC grant, the Department is examining what additional roles we should be playing in regard to AIDS. We have initiated planning efforts and are involving the input of the gay communities, as well as the University of Nebraska Medical Center. As with CMV and Herpes, activites which are described in the following paragraphs, the Department feels strongly that we must be proactive and must work cooperatively with other groups in effectively reacting to this disease.

Cytomegalovirus and Herpes Infections: Many of you are likely aware of the case in Council Bluffs last year in which a young child was excluded from public school because she had been diagnosed as having Herpes Simplex II. Both CMV and Herpesvirus are very common in the population. As a result of seeing unfortunate cases such as occurred in Council Bluffs, we felt that the Department should play a proactive role in assisting the medical, legal and educational professions to jointly consider appropriate handling of such cases before more have occurred. To this end the Department sponsored a conference on August 22 and 23, in order to arrive at consensus among representatives of these four professions regarding appropriate administrative approach and regarding the risk imposed by school children infected with herpes or shedding CMV. We expect the proceedings of this conference to be available later this Fall and believe they will be helpful in guiding schools and the medical community when dealing with children known to be shedding these viruses.

Pesticide Poisoning: Through a cooperative agreement with the Centers for Disease Control, the Department has increased its capacity for monitoring and protecting the health of Nebraska citizens threatened by the use/misuse of chemicals with the emphasis on farm chemicals. We are currently completing the first of what we hope will be a three-year project. The first year's efforts have been directed toward increasing surveillance of farm workers and exposure to pesticides used on farms.

A twenty-one county area in the south central portion of the state emcompassing the population centers of North Platte and Kearney, was selected for the initial demonstration site on the basis of 1) accurate and centralized reporting of medical incidents, and 2) large numbers (17,000 est.) of persons heavily engaged in crop and livestock production. Agricultural production in this area is accompanied by high volume applications of nitrate-containing compounds and pesticides which increases the probabilities for exposure of farm workers. Also, this area has shallow water tables and sandy soil which complicate the maintenance of quality drinking water.

One of the study objectives centered on establishing surveillance of farm worker exposures to pesticides. Physicians in the study area have all been contacted by letter, and in some cases by an on-site visit to request their assistance in reporting suspected pesticide exposure cases to Department of Health personnel at the close of the growing season. The Cooperative Extension Service informs us that the last anticipated date of pesticide application in Nebraska will be 5 September. Department of Health staff will be out in the field collecting case data beginning mid-September.

In conjunction with this grant, we plan to conduct an epidemiological study on the role of the external environment on adverse pregnancy outcomes. The activities included in the plans for this study include: 1) a computerized surveillance system to be developed in the Nebraska Department of Health for birth defect cases based on a combination of Nebraska and national averages, 2) adverse pregnancy outcome data base accumulated over the past twelve years to be analyzed for various trends and potential correlations with other birth or environmental problems, and 3) birth defect cases in recent years to be utilized to determine potential areas of underreporting.

Respectfully submitted,
Gregg F. Wright, M.D.
Director

REPORT OF THE NEBRASKA FOUNDATION FOR MEDICAL CARE

On September 30, 1985, the Nebraska Foundation for Medical Care will have completed its first year of operation as the Professional Review Organization (PRO).

To say the least this has been an eventful year as NFMC implemented a program of review of Medicare hospital admissions for Nebraska.

There have obviously been problems, mistakes, delays, pressures, criticism and all of the other nuances as would be expected with the implementation of a program of this magnitude where no previous activity of this nature had existed.

Despite all of this, I sincerely feel the Foundation has reached its first anniversary in good condition and that the program goals and objectives established are being met.

One year ago no one in Nebraska had any experience with review programs. We started from scratch. But with perserverance, determination, cooperation and considerable effort by many physicians and staff we have learned many valuable lessons. In the year to come we will make every effort to use this experience to streamline our programs and make them function for the ultimate benefit of the patient and the profession.

This program as you are aware is keyed to physician participation and to that point we have made every effort to share with you the procedures and requirements of the PRO law. You have responded to our requests for physician reviewers but there is always need for additional participants and I invite you to sign up with NFMC in this capacity if you have not done so previously.

The Foundation recognizes the need for ongoing education and we are currently planning a second series of combined information and physician reviewer meetings across the state. These meetings will be announced both by the Foundation and appear in the NMA Newsletter. We hope many of you will be able to attend.

As we move into the second year of operation, I do wish to take this opportunity to extend recognition and appreciation to the Kansas Foundation for Medical Care which has provided invaluable services as sub-contractor for the technical component of our program. We are deeply appreciative of the efforts of their staff who have been of immense assistance in the implementation and operation of the Nebraska PRO.

I would also like to recognize the efforts of the NFMC staff who have worked diligently to carry out their responsibilities of this complex program. They are professionals with dedication to doing the best job possible. I know they will continue to carry out their duties in a like manner during the coming year.

In conclusion, I extend the sincere appreciation of the officers and board who are your colleagues, for your participation in this program. Medicine through the Foundation has accepted a difficult challenge. That challenge is being met.

Respectfully submitted
Herbert E. Reese, M.D.
President

REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

Craig L. Urbauer, M.D., Lincoln - Chairman; Charles S. Wilson, M.D., Lincoln - Vice Chairman; Dwaine J. Peetz, M.D., Neligh - Advisor & Counselor; Patrick E. Brookhouser, M.D., Omaha; Judith A. Butler, M.D., Superior; James H. Dunlap, M.D., Norfolk; Vernon F. Garwood, M.D., Lincoln; Barbara M. Heywood, M.D., Papillion; Ronald W. Klutman, M.D., Columbus; Dennis G. O'Leary, M.D., Omaha; Robert G. Osborne, M.D., Lincoln; Paul M. Paulman, M.D., Omaha; Richard A. Raymond, M.D., O'Neill. Herbert E. Reese, M.D., Lincoln; Blaine Y. Roffman, M.D., Omaha; Myland R. VanNewkirk, M.D., Scottsbluff; Jerald R. Schenken, M.D., Omaha; Kathy Hedges, Omaha; Douglas Foulk, Omaha; Sam Cullan, Omaha.

Much of the activity of the Commission has previously been reported at the Annual Session and in periodic Newsletters regarding final status of legislation and other ongoing legislative activity.

The purpose of this report will therefore cover only those events that have taken place since Annual Session and some observations concerning the upcoming 1986 session.

Principal activity since the close of the 1985 Legislature has centered about implementation of LB 407 the credentialing bill supported by the NMA.

As of this date, the Department of Health has developed procedures and guidelines for the implementation of this new process. At this juncture a word of appreciation should be noted for the efficient work of the Department of Health personnel under the direction of Gregg Wright, M.D, Director. They have met the time mandates of the Legislature which required them to establish the protocol for the program, create and appoint the necessary technical review committees, hold public hearings and provide reports and recommendations from the Department prior to the end of the year.

Public hearings for those groups seeking either expansion of their practice or recognition by the state have been established.

Personnel for all committees has been established and appointed.

As indicated in earlier reports a number of study resolutions were adopted and we can expect to see activity on these resolutions during the fall months. The NMA has received requests for physicians to be appointed to several of these committees to date.

The 1986 session will convene in January for a 60-day session and we again anticipate an active session on health issues. A number of bills from the 1985 session were not acted upon and will be carried over in their present status into 1986. In addition, several issues namely pre-judgment interest and living wills are again expected to be on the calendar for consideration. There is also the possibility of professional liability amendments. This matter is currently under consideration by an ad-hoc committee of the Association.

On behalf of the Commission, I wish to express our thanks and appreciation for the interest shown by members during the last legislative session. Your appearance at public hearings and contacts with the Senators is still a vital part in expressing the opinion of medicine to those representatives who make our laws.

REPORT OF THE COMMITTEE ON HEALTH PLANNING

C. J. Cornelius, Jr., M.D., Sidney - Chairman; Gordon D. Adams, M.D., Norfolk; Lewiston W. Birkmann, M.D., Lincoln; James S. Carson, M.D., McCook; Chris C. Caudill, M.D., Lincoln; Allen D. Dvorak, M.D., Omaha; Dale W. Ebers, M.D., Lincoln, Louis J. Gogela, Jr., M.D., Beatrice; Duane W. Krause, M.D., Fremont; Roger D. Mason, M.D., Omaha; Donald F. Prince, M.D., Minden; C. Lee Retelsdorf, M.D., Omaha; Thomas H. Wallace, M.D., Gordon; Mr. Mark Pitner, Omaha.

Health Planning activities continue to be rather sluggish but are expected to pick up in the very near future. The 4th Edition of the State Health Plan is due to be released for public review and comment within the next 2-3 months and will be reviewed by your Committee. It is also note-worthy that the Statewide Health Coordinating Council in conjunction with the Department of Health is sponsoring a one-day conference in Lincoln on October 24th, on the Ethics of Rationing of Health (Medical) Care. Speakers and panelists invited to participate to date include: David Kinser, Past President of the Massachusetts Hospital Association; Norman Daniels, PhD of the Philosophy Department at Tufts University; and Leo Henikoff, M.D., a Pediatric Cardiologist and President of the Rush-Presbyterian/St. Lukes Medical Complex and a member of the AMA's Council on Ethical and Judicial Affairs. An economist and a jurist or politician have also been invited. Attendance will be by invitation and the conference proceedings will be video taped so that it can be made available to numerous civic and service groups for maximum impact. This conference has great potential for public education regarding moral and ethical dilemmas in the delivery and financing of medical care particularly for the poor and the medically indigent.

Doctors Bosley, Mason and your Committee Chairman are members of the planning committee for this conference and are very encouraged by the direction and potential of this conference. Additional information will be made available to the Reference Committee as the plans, speakers, and format should be finalized before the SHCC meeting of September 27th. The NMA is requested to assist in the financial support of this conference. It is recommended that the NMA pledge $500.00 to this program which would cover the expenses of travel and lodging for the AMA participant, Doctor Henikoff.

Your committee chairman will be attending a meeting of the Advisory Committee of the AMA's Health Policy Agenda for the American People on September 5th to consider an additional 15 policies proposed by the HPA work groups. This process is in its final stages and should be completed early in 1986. The impact of this process is yet to be determined. It is the AMA's hope that the principles and policies developed through this process can be transmitted to Congressional staffs and committees involved in the development of health care legislation and regulation. Updated information will be available to the Reference Committee regarding this latest meeting.

Your Committee on Health Planning will review the latest edition of the State Health Plan when it is released for the review and comment, and will prepare comments for the NMA Board of Directors' consideration at the appropriate time.

REPORT OF THE TASK FORCE ON ALTERNATE HEALTH PLANS I

C. J. Cornelius, Jr., M.D., Sidney - Chairman; Warren G. Bosley, M.D., Grand Island; Dale W. Ebers, M.D., Lincoln; Vernon F. Garwood, M.D., Lincoln; Richard H. Meissner, M.D., Omaha; Donald Pavelka, M.D., Omaha; Michael J. Haller, M.D., Omaha; Roger D. Mason, M.D., Omaha.

The Task Force met at the NMA Headquarters on July 19, 1985. Information regarding the Medical Association sponsored IPA's of Georgia and South Dakota, a primary care IPA in Minnesota, and a Cincinnati, Ohio IPA (Choice Care), were presented and discussed. Information regarding a physician sponsored IPA, "Physicians Health Plan" in Omaha under contract with "Charter Med" was also received and reviewed.

After lengthy deliberation, it is the concensus of your Task Force that the NMA continue to monitor developments in the "Alternate Delivery" area but limit its activities to generic contract review and general recommendations.

Your Task Force will continue to consider any significant changes in the Alternate Delivery climate and make additional recommendations as appropriate.

REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

Warren G. Bosley, M.D., Grand Island - Chairman; Stephen J. Lanspa, M.D., Omaha; Eileen C. Vautravers, M.D., Lincoln; Paul Phillips, M.D., Scottsbluff; Wesley G. Wilhelm, M.D., Omaha; Gregg F. Wright, M.D., Lincoln.

The Committee has had no formal meeting since its last report to the House of Delegates, but efforts continue to identify and meet with representatives of groups interested in this subject. These meetings will be arranged during the fall and winter. This will include representatives of corporations who sponsor health education and fitness programs for their employees; representatives of the State Department of Education; representative of collegiate-level programs in Physical Education and Health Education. The Committee will continue to work closely with state-level programs in Health Education and fitness. The Committee will identify and meet with people interested in sports and fitness activities that can be maintained throughout an individual's life. A report on these activities will be submitted to the next meeting of the House of Delegates at the annual session.

REPORT OF THE AD-HOC COMMITTEE ON HEALTH POLICY STATEMENTS

C. Lee Retelsdorf, M.D., Omaha - Chairman; Charles L. Barton, M.D., Lincoln; Daniel S. Durrie, M.D., Omaha; Darroll J. Loschen, M.D., York; Dale E. Michels, M.D., Lincoln; Robert F. Shapiro, M.D., Lincoln; Charles S. Wilson, M.D., Lincoln; Frederick Youngblood, M.D., Omaha.

The Ad-Hoc Committee on Health Policy Statements was assigned the responsibility of developing position papers for consideration by the House of Delegates.

The Committee presents these statements to the House for approval at this Session.

NEBRASKA MEDICAL ASSOCIATION HEALTH POLICY STATEMENTS

Advertising and HMOs

The NMA believes a physician may provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members or subscribers through advertising. Physicians practicing in prepaid plans or HMOs are subject to the same ethical principles as are other physicians. Advertising which would lead prospective members or subscribers to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members or subscribers, if in fact this is not so, is deceptive. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information is not a deceptive practice.

Advertising and Publicity

According to the NMA there are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television or other advertising) provided that the communication shall not be midleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

The form of communication should be designed to communicate the information contained therein to the public in a direct, dignified and readily comprehensive manner. Aggressive, high pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content, shall be true and not misleading.

The communication may include the following: (1) the educational background of the physician; (2) the basis on which fees are determined (including charges for specific services); (3) available credit or other methods of payment; and (4) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services.

Testimonials of patients, however, as to the physician's skill or the quality of his professional services should not be publicized. Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards. Claims regarding experience, can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy. A statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment may imply a certainty of result and create unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio or television, should determine in advance that his communication of message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered.

As used herein, reference to a "physician" applies also to information relating to the physician's group, partners or associates. Any communication or message within the scope of this opinion should include the name of at least one physician responsible for its content.

Allocation of Health Resources

The NMA believes that a physician has a duty to do all that he can for the benefit of his individual patients without assuming total responsibility for equitable disbursement of society's limited health resources. To expect a physician in the context of his medical practice to administer governmental priorities in the allocation of scarce health resources is to create a conflict with the physician's primary responsibility to his patients that would be socially undesirable.

Limited health care resources should be allocated efficiently and on the basis of fair, acceptable and humanitarian criteria. Priority should be given to persons who are most likely to be treated successfully or have long-term benefit. Social worth is not an appropriate criterion.

Utility or relative worth to society should not determine whether an individual is accepted as a donor or recipient of tissue for transplantation, selected for human experimentation, or denied or given preference in receiving scarce health care treatment or resources.

Autopsy

The NMA believes that members of the health care team should be reminded that the medical autopsy is an important aspect of medical education and the bedrock support of quality assurance in medical care. For this reason, routine autopsy after hospital death is to be encouraged in all hospitals, but especially in teaching institutions. It is recommended that the performance of autopsies should be a recognized hospital expense which the hospital is entitled to recover through its rate structure.

Automobile Safety

The NMA recognizes that children in automobiles should receive protection through the proper use of approved restraint systems.

The NMA again emphasizes its support for use of restraint systems in autos.

The NMA believes that physicians should assume the leadership in preventing injury and illness, and the prevention of injuries in motor vehicle crashes should be one of their major concerns.

Family Practice

The NMA believes a family physician is a personal physician, oriented to the whole patient, who practices both scientific and humanistic medicine. He usually provides medical care in more than one of the traditional specialty fields of medicine and coordinates the care obtained by referral to or consultation with other physicians. He assumes responsibility for the patient's comprehensive and continuing health care and in effect serves as captain of the health team.

The family physician is involved in the discipline of family practice. His other training and experience qualify for practice in several fields of medicine and surgery, with particular emphasis on the family unit.

He serves the public as a physician of first contact and means of entry into the health care system. The physician evaluates the patient's total health needs, providing personal medical care within one or more fields of medicine, and refers the patient, when indicated, to appropriate sources of care while preserving the continuity of care.

The family physician accepts responsbility for the patient's total health care, including the use of consultants, within the context of their environment, including the community and the family or comparable social unit.

Free Choice of Physicians

The NMA believes that free choice of physicians is the right of every individual. A person may select and change physicians at will, or choose a medical care plan such as that provided by a closed panel or group practice of health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.

In choosing to subscribe to any alternate health care delivery system or in choosing or accepting treatment in a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.

The need of an individual for emergency treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice of physician, particularly where there is loss of consciousness.

Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient. In selecting the physician of choice, the patient may sometimes be obliged to pay for medical services which might otherwise be paid by a third party.

Contractual Relationships

The NMA believes that the contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The NMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patient they serve.

Health Education

The Nebraska Medical Association supports comprehensive school health education programs in kindergarten through grade 12 and encourages physicians to implement patient education programs in their offices.

Health Facility Ownership by Physician

The NMA believes that a physician may own or have a financial interest in a for-profit hospital, nursing home or other health facility, such as a free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to this patient, prior to admission or utilization. Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward of financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial benefit would be unethical.

If a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Health Planning

The Nebraska Medical Association supports voluntary, community-based health planning that originates from the expressed will of the community without statutory mandate. Health Planning is a process of determining community needs and priorities and assisting in the development and allocation of resources to meet those needs. The NMA believes that the following six principles should be considered in the creation and implementation of voluntary health planning: (1) health planning should be the function of a collaborative group of community representatives; (2) health planning should function under a constitution and by-laws and play an informational and educational role; (3) recommendations should be advisory and responsibility for implementation should rest with those most directly involved; (4) the size of the area, scope of planning activities and employment of planning staff should be determined by the community; (5) there should be a commitment from the community-at-large to support and finance a planning organization operation; and (6) health planning should use positive incentives to attain community objectives and should not have regulatory authority or use of regulatory sanctions.

Interest Charges and Finance Charges

The NMA believes that although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the physician's waiting room, the distribution of leaflets describing the office billing practices and appropriate notations on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. The NMA encourages physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time to make exceptions in hardship cases.

The Ad-Hoc Committee on Health Policy Statements presents this report for consideration by the House.

REPORT OF AD-HOC COMMITTEE, LOW LEVEL RADIATION WASTE DISPOSAL

Richard J. Petersen, M.D., Omaha - Chairman; Allen D. Dvorak, M.D., Omaha; Stanley Jaeger, M.S., Omaha; Martin R. Lohff, M.D., Omaha; Merton A. Quaife, M.D., Omaha; Jerald R. Schenken, M.D., Omaha; Paul Steffes, M.D., Omaha.

The Ad-Hoc Committee on Low Level Radiation Waste Disposal has not had a necessity to meet since its formation in June of 1985.

Informational materials have been distributed to the membership of the Committee, relative to the overall question of low level radioactive waste disposal and specifically, the situation in the State of Nebraska at this time.

REPORT OF THE AD-HOC COMMITTEE ON PROFESSIONAL LIABILITY

James H. Dunlap, M.D., Norfolk - Chairman; Warren Bosley, M.D., Grand Island; Ernest Chupp, M.D., Omaha; Gernon A. Longo, M.D., Omaha; Dwaine J. Peetz, M.D., Neligh; Herbert E. Reese, M.D., Lincoln; Blaine Y. Roffman, M.D., Omaha; Robert F. Shapiro, M.D., Lincoln.

Your committee has met on two occasions since the last meeting of the House of Delegates. Additionally, we have had numerous communications from and with a wide variety of people dealing with the insurance commissioner's office, the St. Paul Insurance Company and innumerable other individual contacts dealing with liability problems and prospective legislative activities.

At the moment, we are engaged with a number of themes dealing with tort charges in connection with the Nebraska Hospital-Medical Liability Act. Whether or not we will propose these changes during the 1986 Nebraska Legislature session will depend upon actuarial studies currently being planned and upon an assessment of the political composition of the Legislature in addition to other factors. We have maintained a liaison with the Nebraska insurance commissioner's office and are pleased with this relationship.

Additionally, plans are being formulated for an anticipated professional liability seminar to preceed the State Medical Association annual meeting in 1986. This will deal with the general theme of surgical risks and is anticipated to meet the St. Paul Insurance Company's criteria for premium benefits. Additionally, plans are under way to develop a series of short video tapes suitable for 3rd and 4th year residents and hospital staff educational presentations.

We are aware of prospective federal legislation which is in draft status from the American Medical Association and are planning to coordinate our own legislative endeavors with such prospective AMA sponsored legislation.

REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

John D. Coe, M.D., Omaha - Chairman; R.A. Blatny, M.D. Fairbury; Bernard Kratochvil, M.D., Omaha; Arnold W. Lempka, M.D., Omaha; Walter O'Donohue, M.D., Omaha; Herbert E. Reese, M.D., Lincoln; Joseph E. Stitcher, M.D., Lincoln; R. C. Weldon, M.D., Nebraska City; Mr. Don Graham, Omaha.

The Commision on Association Affairs presents the following report to the House of Delegates. The report presents specific Article and By-Law amendments as directed by the House of Delegates at the Annual Session, 1985. These segments of proposed wordage cover the associate member category and a life membership benefit category. We have also incorporated the wordage which reorganizes the commission/committee section of the By-Laws as directed by the House.

In addition, we are proposing wordage which would provide that recently licensed graduates of osteopathic schools be accepted as members of the Association.

(1) ASSOCIATE MEMBER CATEGORY IN THE NMA - The House directed that there be established an associate member category for persons who retire from medicine and do not pursue another medically-related career, do not receive any compensation relative to their M.D. degree, do not meet the criteria for life membership status, and specifies that retirement take place after 25 years in practice. The House directed the associate member pay for the services from the NMA including the Journal, mailings, etc.

The following wordage would be necessary to implement this change:

That Article VIII, Section 3 of the Articles of Incorporation be amended to read as follows:

Section 3. Members of the Association shall be classified as (1) active, (2) house officer, (3) honorary, (4) life, (5) associate, (6) student.

That Chapter I, Section 6, of the By-Laws be amended to read as follows:

> **Section 6. Associate membership may be granted to any member in good standing who does not meet the qualifications for life membership, but who has been in practice for twenty-five (25) years and who has retired from medicine and has not and does not intend to pursue another medically-related career.**
>
> **An Associate member shall be exempt from the payment of dues, except that Associate members may only receive publications of the Nebraska Medical Association upon payment of a fee to be set by the Board of Directors.**
>
> **An Associate member may vote and hold office, and may participate and attend regular sessions.**

That former Chapter I, Section 6, of the By-Laws be designated as Chapter I, Section 7; that former Chapter I, Section 7, of the By-Laws be designated as Chapter I, Section 8; that former Chapter I, Section 8, of the By-Laws be designated as Chapter I, Section 9; that former Chapter I, Section 9, of the By-Laws be designated as Chapter I, Section 10; and that former Chapter I, Section 10, by the By-Laws be designated as Chapter I, Section 11.

(2) LIFE MEMBERSHIP BENEFITS - The House adopted the position that Life members be charged a minimal fee for the Nebraska Medical Journal with the option of not taking it. To implement this change in the By-Laws the following wordage is proposed:

That the third paragraph of Chapter I, Section 5, of the By-Laws be amended to read as follows:

> **Section 5. A life member shall be exempt from payment of dues; may vote and hold office; may participate and attend regular sessions; and may receive all publications upon payment of a fee to be set by the Board of Directors.**

That Chapter XV, Section 2 of the By-Laws be amended to read as follows:

> **Section 2. The Journal shall be published monthly and mailed to each active member, house officer member, honorary member, and student member of the Nebraska Medical Association who is in good standing and, on request, to all new and reinstated members, commencing with the first issue of the year in which dues are received in the office of the Secretary-Treasurer, provided that such copies are available. Life members and Associate members shall be entitled to receive the Journal upon payment of an additional fee to be set by the Board of Directors. The Journal may contain the scientific papers and proceedings of the annual session and minutes of the Board of Councilors and Board of Directors. It shall contain the minutes of the meetings of the House of Delegates, notices of regular and special meetings, advertising and such other matter as may be of interest to members. Editorials shall be given prominent place in the Journal.**

That Chapter X, Section 1(14), of the By-Laws be amended to read as follows:

> **(14) Be responsible for setting the fee to be charged to Life members and Associate members for receipt of the Journal of the Nebraska Medical Association.**

That former Chapter X, Section 1(14) of the By-Laws be designated as new Chapter X, Section 1(15).

(3) OSTEOPATHIC PHYSICIAN MEMBERSHIP IN THE NMA - The Commission on Association Affairs was notified that there are recent graduates of osteopathic schools serving as residents and practicing physicians in this state. It was further brought to our attention that there is interest by these physicians in becoming members of the Association and to accomplish that provision the following change in the Articles of Incorporation is recommended.

That Article VIII, Section 2, of the Articles of Incorporation be amended to read as follows:

> **Section 2. Every reputable physician licensed in the State of Nebraska and holding the degree of Doctor of Medicine or Bachelor of Medicine and every reputable osteopath licensed in the State of Nebraska under Neb. Rev. Stat. §71-1, 141(2) and (3) (Reissue 1981), shall be eligible for membership in a component society.**

(4) RESTRUCTURING OF COMMISSIONS/COMMITTEES - The House of Delegates considered a long range planning report presented by the Board of Directors during the Annual Session deliberations in 1985. The proposal was adopted and the restructuring of the By-Laws is now presented. In this portion of the report, we are reproducing the entire segment of the By-Laws covering Commission and Committee activities noting the changes which are being proposed.

CHAPTER XIII - COMMISSIONS AND THEIR DUTIES

SECTION 1. Each commission of this Association shall consist of at least seven members appointed annually by the President-Elect. The President-Elect may also appoint members and non-members to commissions and ad hoc committees on an interim basis.

The President, the President-Elect, and the Secretary-Treasurer shall be ex-officio members of all commissions and committees, without the right to vote, except as otherwise provided in the By-Laws.

The House of Delegates may by motion create new, or abolish old commissions and committees at their discretion. Members of all commissions shall continue to serve until their successors are appointed.

SECTION 2. Members of all commissions and committees shall be appointed annually, except as otherwise provided. Subject matter to be considered by the commissions shall include that indicated in the

Articles and By-Laws and such other matters as may be referred to, or of interest to, the commissions. The reports of all commissions shall be presented to the Board of Directors, together with their recommendations, and shall be referred to the House of Delegates for disposition at its next session.

In appointing commission members, geographic distribution shall be kept in mind in order to obtain broad representation. At the discretion of the President, upon the recommendation of the House of Delegates or upon the request of a commission chairman, an ad hoc committee of five members shall be appointed by the President as requested. One member of the appropriate commission will be appointed to serve as chairman of the ad hoc committeee made up of four additional non-commission members. The ad hoc committee will cease to exist when it has completed its task or at the close of the next Annual Session of the Association.

The Commission of the Association shall be as follows:

A. The Commission on Association Affairs shall in and of itself, or through the utilization of ad hoc committees:

(1) Concern itself with insurance contracts pertinent to the practice of medicine and of importance to the Association member. Serve as a liaison between members of the Nebraska Medical Association and all health insurance carriers. No member shall be eligible to serve on this commission, who is an officer or director of Blue Cross & Blue Shield of Nebraska.

(2) Consider all suggestions made to revise or amend the Articles and By-Laws, compose the provisions for such amendments, and present them to the House of Delegates for adoption or revision as provided in Article XV of the Articles and/or Chapter XVI of the By-Laws of the Nebraska Medical Association.

(3) Cooperate with and foster the relationship between the Auxiliary of the Nebraska Medical Association and the Nebraska Medical Association.

(4) Develop and implement programs for orientation and promotion of membership in organized medicine to the medical student, house officer and non-member physicians in Nebraska.

(5) Provide for the maintenance of a permanent record of house actions and organization policies for purposes of efficient and responsive referral. Be responsible for such other matters, as may be assigned to the commission by the House of Delegates or the Board of Directors.

(6) Develop and maintain statistical data relating to Physician Manpower in the State of Nebraska.

(7) Study and explore various activities and programs which would augment Association revenues.

(8) Analyze electronic mechanisms including computers which may have a continuing applicability to physician practices with the intent of providing information on products and services available to members of the Association.

(9) Be responsible for creating a permanent Scientific Sessions Committee which shall be composed of physicians who have shown an interest in continuing medical education and who have indicated a desire to serve on said committee. At least one member of the committee shall have training and experience in professional education. At least one member shall be a member of the American Academy of Family Physicians. Members of the Committee shall be appointed by the President after recommendation for such appointment by the Commission on Association Affairs. Committee members shall be appointed for terms of three years. Terms shall be staggered to provide continuity in the committee. Members may be re-appointed for additional terms. One of the committee members who has served on the committee or its predecessor committee for at least two years shall be designated as Chairman. The Chairman shall be designated annually and may be re-appointed from year to year. The Chairman shall be an ex-officio member of the committee for at least one more year after termination of his position as Chairman. The Chairman in collaboration with the committee shall be directly responsible for all continuing medical education activities of the Association. One member of the committee shall be designated as Convention Chairman each year who will act as Chairman of the Annual Session for said year. The Convention Chairman may be the Chairman of the Committee or any other member of the Committee who has served for one year and will be a member of the Committee for at least one year after the Annual Session.

The Scientific Sessions Committee shall be responsible for the Annual Session of the Association, including selection of dates, and shall have charge of all proceedings at the meeting except those of (a) the House of Delegates, (b) the Board of Councilors, and (c) the Board of Directors. It shall be obligated to arrange for the scientific programs at the Annual Session and to publish the program in the Nebraska Medical Journal immediately preceding the Annual Session and to issue supplemental programs to members and others by mail.

The Scientific Sessions Committee shall also be responsible for sponsoring or co-sponsoring continuing medical education programs.

B. The Commission on Medical Services shall in and of itself, or through the utilization of ad hoc committees:

(1) The Commission on Medical Service or its committees shall concern itself with all school athletic programs, and establish appropriate guidelines based on data obtained from physicians and

school officials. Stimulate development of postgraduate programs in school athletics for physicians and school officials keeping them abreast of new advancements in the field.

(2) Concern itself with current matters and information relating to cancer and disseminate information to physicians and the public, as deemed appropriate.

(3) Concern itself with emergency medical service planning and operation, and disseminate information regarding emergency preparedness. Cooperate and consult with other agencies developing and publicizing programs and activities concerning emergency services.

(4) Concern itself with the field of geriatrics and accompanying problems, and recommend programs accordingly.

(5) Concern itself with problems in the field of maternal and child health, and provide current information to members of the Association, as deemed appropriate.

(6) Concern itself with current progress and problems of mental health, and keep the membership informed of such activities, as may be of interest in this field.

(7) Concern itself with matters relating to public and occupational health, and bring such information to the attention of the profession, as deemed appropriate.

(8) Concern itself with cardio-vascular problems and disseminate information relating thereto to physicians and the public.

(9) Concern itself with any other health problems the Commission deems appropriate.

(10) Represent the Association in the various facets of quality assurance with which the Association should become involved.

(11) Concern itself with matters relating to the standards and ethics of the profession.

(12) Concern itself with monitoring various alternate delivery systems underway or being proposed for the citizens of Nebraska.

(13) Concern itself with the various physician inter-relationships of importance to members of the Association.

(14) Study and monitor the various pricing mechanism being utilized within the State of Nebraska.

(15) Concern itself with the subject of indigent care.

(16) Review, study and when applicable propose various programs having to do with the general subject of wellness as it relates to Nebraska citizens.

(17) Concern itself with medicine/business coalitions and represent the Association in various endeavors in this regard.

C. The Commission on Legislation and Governmental Affairs shall in and of itself, or through the utilization of ad hoc committees:

(1) Develop and continually update a plan for medical service in Nebraska, seeking counsel and recommendation from all groups interested and involved in health care and its delivery.

(2) Serve as liaison with state governmental agencies to establish communication, as appropriate.

(3) Consider various governmental programs from the standpoint of the potential relationship the Association should have with these programs.

(4) Consider matters of a legislative and regulative nature at the federal level which would affect the practice of medicine.

(5) Consider matters of a legislative and regulative nature at the state level which would affect the practice of medicine.

(6) Serve as the legislative authority in behalf of the Association and provide for organizational input and testimony, when deemed appropriate.

(7) Provide advice and counsel in matters of a legal nature affecting Nebraska physicians.

(8) Monitor national activities which have an influence or bearing on the practice of medicine by members of the Association.

(9) Monitor the various activities taking place locally and nationally in order to maintain an atmosphere of political awareness in behalf of members of the Association.

(10) Concern itself with the general subject of Professional Liability as local and national activities and influences affect the members of the Association.

(11) Concern itself with professional discipline as it relates to the various functions assigned to the Commission on Legislation and Governmental Affairs and aside from the responsibilities of the Board of Councilors and the Council on Professional Ethics.

D. The Commission on Medical Education shall in and of itself, or through the utilization of ad hoc committees:

(1) Concern itself with medical education in Nebraska, serving as a liaison committee between the two medical schools of the state, concern itself with and make recommendation regarding postgraduate education for the physicians of the state, and shall be responsible for approving and providing accreditation to organizations and institutions for continuing medical education programs.

(2) Concern itself with health education in the

school system, including the study and evaluation of the teaching of health education in the elementary and secondary schools, and colleges in cooperation with key educators.

(3) Concern itself with creating the proper climate for communication between the physician and the clergyman that will lead to the most effective care and treatment of the patient.

(4) Foster the practice of medicine in rural Nebraska and cooperate with organized farm groups, as deemed appropriate.

E. The Commission on Public Affairs shall in and of itself, or through the utilization of ad hoc committees:

(1) Collate and activate the joint purposes of the allied professions pertaining to the health of people of the State of Nebraska.

(2) Be concerned with the ethics, responsibilities, standards, contractual relations, general policies and procedures relevant to medical practice in hospitals.

(3) Be responsible for the public relations activities carried on by the Association.

(4) Be responsible for interprofessional communication directed at the members of the Association.

F. The Commission on Hospital Medical Staff shall in and of itself, or through the utilization of ad hoc committees.

(1) Obtain and disseminate information to the medical community via medical staff relative to all pertinent, common problems.

(2) Increase awareness among physicians about such issues as relationships to regulatory agencies, third-party carriers, accreditation bodies, administrators and board of trustees.

(3) Promote interchange of ideas between physicians in varying practice settings and define and identify areas of concern and interest.

(4) Provide a body of medical staff solidarity lending support for such individual or unified projects as may effect medical staffs and/or individual physicians.

(5) Assure the position of the physician as the primary provider of health care.

(6) Act as patients' advocate to maintain the highest quality of care.

(7) Serve as the Association representative group regarding MD/Hospital relationships.

(8) Serve as a resource for such activity areas as joint ventures, free-standing clinics, surgicenters, networking, etc.

(9) Be a resource for informational materials.

The Commission respectfully submits these Article and By-Law amendments to the House of Delegates with the recommendation they be adopted.

Board of Councilors

The Fall Session meeting of the Board of Councilors was held September 19, 1985, at the Cornhusker Hotel, Lincoln, Nebraska.

Members present were Drs. Stanley Truhlsen, Howard Dinsdale, C. T. Frerichs, Roger Massie, Wm. Chleborad, Robert Herpolsheimer, Robert Quick, Floyd Shiffermiller, Warren Bosley, Francis Donahue, Hiram Walker and Herbert Reese.

The meeting was called to order by Dr. Donahue, Chairman pro-tem.

Dr. Donahue called for approval of the minutes of the Annual Session meeting of the Board of Councilors, and these were approved as printed in the July, 1985, issue of the Journal.

The Councilors considered and discussed the reports and resolutions contained in the Handbook, and these were referred on to the House for their consideration.

The list of 50-year practitioners and the request for Life Membership were approved by the Board of Councilors.

Election of the Chairman and the Secretary of the Board of Councilors was called for, and a motion was made that the current Chairman and Secretary be retained for another year. This was approved by the Board of Councilors.

Mr. Neff discussed membership recruitment. The Councilors were informed that the Board of Directors had referred this to the Board of Councilors. Mr. Neff gave a brief outline of recruitment of the new physicians coming into the state, the delinquent members and the non-members. Dr. Truhlsen indicated that he would appoint an ad-hoc committee to work with the Headquarters Staff in carrying out this program.

There being no further business, the Board of Councilors was adjourned.

House of Delegates

FIRST SESSION

The First Session of the House of Delegates was held September 20, 1985, at the Cornhusker Hotel, Lincoln, Nebraska. Roll call showed 78 delegates present, and the House was declared in session.

The meeting was called to order by Dr. McFadden, Speaker. Approval of the Annual Session minutes was called for, and these were approved as printed in the July, 1985, issue of the Journal.

Oral reports were presented as follows:

Dr. Robert Waldman, Dean, University of Nebraska College of Medicine
Dr. Gregg Wright, Director, State Department of Health

Reports and resolutions were assigned to Reference Committees as follows:

REFERENCE COMMITTEE #1

- Report of the Board of Directors, Item #1, Finance Report
- Report of the Ad-Hoc Committee on Health Policy Statements
- Resolution #2 - Lancaster County - AMA Principles of Medical Ethics
- Resolution #5 - Sarpy County - Blue Cross & Blue Shield of Iowa/Medicare

REFERENCE COMMITTEE #2

- Report of the Board of Directors, Items #2, #3, and #4, Membership Report, Unified Membership and Manpower Report
- Report of the Delegate to AMA, Physician Manpower, Benefits of AMA Membership and Unified Membership
- Report I, Board of Trustees of AMA, AMA Membership Benefits

REFERENCE COMMITTEE #3

- Report of the Board of Directors, Items #5 and #6, Care of the Aging and Pre-admission Certification
- Report of Nebraska Foundation for Medical Care
- Report of the Task Force on Alternate Health Plans I
- Resolution #1 - Metro Omaha - Outside Interference in Medical Care
- Resolution #3 - Metro Omaha - Costs of Mandatory Utilization Control Programs
- Resolution #4 - Scotts Bluff County - NMA/PRO Relationship

REFERENCE COMMITTEE #4

- Report of the Delegate to AMA (Except for those items referred to Reference Committee #2)
- Report AAA, Board of Trustees of AMA, Professional Liability Insurance
- Report OO, Board of Trustees of AMA, Professional Liability
- Ad-Hoc Committee on Professional Liability

REFERENCE COMMITTEE #5

- Report of the Department of Health
- Report of the Commission on Legislation and Legal Affairs
- Report of the Ad-Hoc Committee on Low Level Radiation Waste Disposal
- Fifty-Year Practitioners and Life Membership Request
- Resolution #6 - Lancaster County - Health Care Delivery Options

REFERENCE COMMITTEE #6

- Report of Creighton University School of Medicine
- Report of the Committee on Health Planning
- Report of the Ad-Hoc Committee on Health Education
- Report of the Commission on Association Affairs
- Resolution #7 - Lincoln County - Medical Superintendentship of the Lincoln Regional Center

Following announcements, the House was recessed until Saturday morning.

SECOND SESSION

The Second Session of the House of Delegates was held on September 21, 1985, at the Cornhusker Hotel, Lincoln, Nebraska.

The meeting was called to order by the Vice Speaker, Dr. Armstrong. Roll call showed 67 delegates present, and the meeting was declared in session.

Dr. Armstrong called for approval of the minutes of the First Session, and these were approved as printed.

Reports of the Reference Committees were called for and the following presented:

Reference Committee #1

Reference Committee #1 considered two reports and two resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #1, FINANCE REPORT

There was no testimony before the Committee. The Committee reviewed the report, noting that dues makes up a large portion of the income of the Association. The dues income has declined slightly in 1985 as opposed to 1984. The Committee recommends acceptance of the financial report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE AD-HOC COMMITTEE ON HEALTH POLICY STATEMENTS

There was extensive discussion regarding several statements. Discussion favored broadening the statement on "Advertising and HMO's" to include other alternate health care systems. Discussion of the policy statement "Advertising and Publicity" strongly supported the statement. However, there was considerable discussion on the status of a policy statement. The Committee intended that it serve as a policy guideline and not as a code of ethics. It was not intended to require a policing mechanism, but rather to be used as a guideline. Discussion on the policy statement "Family Practice" generally favored the statement. The question was raised as to whether other specialties or areas of medical practice should be similarly defined. This question was not resolved by testimony and the Ad-Hoc Committee on Health Policy Statements requests further input from individual members of the Association. There was comment on the policy statement "Contractual Relationships" calling attention to the fine line between some such relationships and "fee splitting."

Testimony regarding the policy statement "Autopsy" requested that the Ad-Hoc Committee consider a statement on the value and availability of autopsies for all automobile deaths. The Reference Committee wishes to commend the Ad-Hoc Committee on Health Policy Statements and recommends that they continue to develop additional policy statements.

RECOMMENDATIONS

(1) The Reference Committee recommends approval of the health policy statement "Advertising and HMO's" with the exception that the title be changed to "Advertising and Alternate Care Systems Including HMO's".

(2) The Reference Committee recommends approval of the health policy statement "Advertising and Publicity" with the understanding that it represents guidelines rather than a code of ethics.

(3) The Reference Committee recommends approval of the health policy statements entitled "Allocation of Health Resources", "Autopsy", "Automobile Safety", "Family Practice", "Free Choice of Physicians","Contractual Relationships", "Health Education", "Health Facility Ownership by Physician", "Health Planning" and "Interest Charges and Finance Charges".

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) RESOLUTION #2 - LANCASTER COUNTY MEDICAL SOCIETY - AMA PRINCIPLES OF MEDICAL ETHICS

This resolution reads as follows:

WHEREAS, in this age of continuing advances in medical technology and evolving approaches to the delivery of health care services, the medical doctor/patient relationship must continue to be the mainstay of our country's health care system, and

WHEREAS, the practice of medicine is in a period of transition and competition among M.D.'s is increasing in the market place giving rise to the introduction of M.D. advertising, and

WHEREAS, the "Principles of Medical Ethics" adopted by the American Medical Association are standards of conduct which define the essentials of honorable behavior for the physician, and

WHEREAS, the current legal climate regarding advertising indicates that Section 5.01 of the Principles of Medical Ethics is not compatible with the present legal environment;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association introduce a resolution to the Hosue of Delegates of the AMA requesting that the AMA "Principles of Medical Ethics" be revised (special attention to Section 5.01) to clarify and update the language to seek an appropriate balance between AMA professional standards and current legal standards in a changing society, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association report to its Spring, 1986 House of Delegates the status of this Lancaster County Society resolution.

There was extensive discussion on this resolution. It was proposed because of difficulties encountered by a component society in attempting to reconcile behavior of a member of that society with the AMA's "Principles of Medical Ethics." It appears that current legal standards make any disciplinary action based on Section 5.01 hazardous from legal, financial and public relations standpoints. The component society asks if they are violating their charter by allowing members to violate the code of ethics. There was considerable testimony favoring the principles of medical ethics as valuable guidelines. However, it was felt that they should be clarified and redefined.

The Reference Committee recommends approval of Resolution #2, with rewording of WHEREAS #4 to read:

"WHEREAS, the current legal climate regarding advertising indicates that Section 5.01 of the "Principles of Medical Ethics" is not compatible with the present legal environment and causes serious conflicts within component societies and possibility of inappropriate legal risks;"

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and discussion followed. Dr. Cornelius indicated that more specific information would be needed before submitting this resolution to the AMA. Dr. Gogela moved to amend the resolution to allow the Delegates and Alternate Delegates to the AMA to study this in detail and prepare this resolution for introduction in the AMA House of Delegates. This amendment was seconded and approved by the House, and this section of the Reference Committee report was adopted as amended.

(4) RESOLUTION #5 - SARPY COUNTY MEDICAL SOCIETY - BLUE CROSS AND BLUE SHIELD OF IOWA/MEDICARE

This resolution reads as follows:

WHEREAS, Blue Cross and Blue Shield of Iowa is now handling the Medicare claims for the State of Nebraska, and

WHEREAS, they are not providing Omaha area physicians with a toll-free number for physician inquiries, and

WHEREAS, they have given instructions they are not to be called except in absolute emergencies;

THEREFORE, the Sarpy County Medical Society resolves that the Nebraska Medical Association should investigate the situation to insure than an adequate avenue of communication is available to the physicians of Nebraska to manage problems involving Medicare claims.

Testimony before the Committee described several instances of poor communications between Blue Cross and Blue Shield of Iowa/Medicare and Nebraska physicians. These communication failures appear to be related to attempts at minimizing administration costs but appeared to result in significant problems for individual physicians and patients. There is currently no mechanism to resolve such problems.

RECOMMENDATION:

The Reference Committee recommends approval of Resolution #5, with an additional RESOLVE: "THEREFORE, BE IT FURTHER RESOLVED, that the Board of Directors assign to an appropriate committee the responsibility for receiving and evaluating individual problems relating to Blue Cross and Blue Shield of Iowa/Medicare with the goal of lodging formal complaints with HCFA as appropriate and forwarding their findings to the American Medical Association as appropriate."

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF YOUR REFERENCE COMMITTEE #1 REPORT AS

A WHOLE AS AMENDED. This was adopted by the House.

Respectfully submitted,
Robert L. Kruger, M.D., Omaha - Chairman
R. A. Blatny, M.D., Fairbury
Jon J. Hinrichs, M.D., Lincoln

Reference Committee #2

Reference Committee #2 considered four reports. The Reference Committee submits the following report and recommendations.

(1) BOARD OF DIRECTORS, ITEM #2, MEMBERSHIP REPORT

Membership continues to show growth in line with increased physician population in the state. Of 2,225 physicians in the state, 1,675 (75%) are NMA members, 1,164 are AMA members.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) BOARD OF DIRECTORS, ITEM #3, UNIFIED MEMBERSHIP

Your Reference Committee recommends this Item #3 for information, with the exception of the last paragraph which we recommend be deleted.

The Committee heard testimony indicating a lack of support for adoption of unified membership at this meeting. The Committee recommends that action be delayed until the Spring Meeting, 1986. The Committee also recommends the formation of an ad-hoc committee to educate the membership concerning the benefits of unified membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and discussion followed. Dr. Cornelius moved to amend the Reference Committee report by not deleting the last paragraph of this Item #3, and that it be accepted for information. This was approved by the House, and this section of the Reference Committee report was adopted as amended.

(3) BOARD OF DIRECTORS, ITEM #4, MANPOWER REPORT

The Reference Committee recommends adoption of this section of the report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) REPORT OF THE BOARD OF TRUSTEES, AMA, REPORT I, AMA MEMBERSHIP BENEFITS

The Committee reviewed this report and felt that this report could be used with supplemental information by the Ad-Hoc Committee on Unified Membership to educate the membership on the benefits of unified membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2 AS A WHOLE AS AMENDED. This was adopted by the House.

Respectfully submitted,
Russell L. Gorthey, M.D., Lincoln - Chariman
Ronald Asher, M.D., North Platte
L. Thomas Heywood, Jr., M.D., Papillion

Reference Committee #3

Reference Committee #3 considered three reports and three resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS ITEMS 5 & 6, CARE OF THE AGING AND PRE-ADMISSION CERTIFICATION

RESOLUTION #3 - METRO OMAHA MEDICAL SOCIETY - COST OF MANDATORY UTILIZATION CONTROL PROGRAMS

Resolution #3 reads as follows:

WHEREAS, employers and insurance companies have introduced into their health insurance plans such provisions as preadmission certification, mandatory second opinions for surgery and preadmission testings, and

WHEREAS, the medical value of preadmission certification and mandatory second opinions for surgery programs remains open to question, and

WHEREAS, these programs are often costly in both time and effort to both the physician and the patient;

THEREFORE, BE IT RESOLVED, that the added expenses for these programs should be covered by all insurers which require them.

Item #5 stimulated discussion relative to concern about elderly patients, and it was pointed out that the Ad-Hoc Committee on Geriatrics has been formed specifically to attempt to deal with these concerns. It was mentioned that increased awareness of the activities of this Ad-Hoc Committee could be obtained by publishing their results in the Journal of the Nebraska Medical Association.

Item #6, relative to pre-admission certification, was discussed in conjunction with Resolution #3 relative to the cost of mandatory utilization control programs. Considerable discussion was heard on these items. It was pointed out that the concept of pre-admission certification, as well as mandatory second opinions, were factors decided upon by benefit managers of large organizations and/or companies. Furthermore, these concepts are seen by these benefit managers to be cost effective and therefore the adoption of these concepts is enthusiastically sweeping the country. It was pointed out that the letter mailed to the physicians from the NMA may have been somewhat misleading as it related to Blue Cross/Blue Shield since Blue Cross/Blue Shield is not the policymaker in this regard, but only acts as the administrator of the program which was established by other benefit managers.

There was considerable testimony at the Reference Committee relative to the aggravation and time involved with pre-admission certification, and this can be summarized by quoting from a letter received by the Reference Committee in which the physician indicated that pre-admission certification is " . . . time consuming, costly, irritating and insulting." However, in view of the fact that this is likely to be a fact of life which must be endured, it was felt the Resolution #3 relative to the expenses associated with these programs was appropriate and should be adopted.

The Reference Committee recommends acceptance of Items #5 and #6 of the report of the Board of Directors as printed.

The Reference Committee recommends approval of Resolution #3 from the Metro Omaha Medical Society as printed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE NEBRASKA FOUNDATION FOR MEDICAL CARE

This report was received for information and very little testimony was heard which related directly to the report. It is recommended that this report be received for information.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REPORT OF THE TASK FORCE ON ALTERNATE HEALTH PLANS I

Considerable discussion was heard relative to this report. Dr. Cornelius elaborated on some of the alternate health plans which the Task Force has been following, particularly those which are being established by the medical societies of Georgia and South Dakota. He pointed out that the Task Force has done considerable work in evaluating and assessing these various alternate health plans and will continue to do so.

There was some question as to the ultimate goal of this task force. It is supposed to monitor and examine alternate health plan activities in order to advise the NMA as to whether it might be appropriate for the NMA to become involved directly in alternate health plans. There is another task force which is charged with the responsibility of providing information to members of the NMA about various aspects of alternate health plans. It was brought out at the Reference Committee that it would be appropriate for the NMA to attempt to keep its membership as informed as possible relative to ongoing developments in this arena.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) RESOLUTION #1 - METRO OMAHA MEDICAL SOCIETY-OUTSIDE INTERFERENCE IN MEDICAL CARE

This resolution reads as follows:

WHEREAS, the physician must be the patient's advocate, and

WHEREAS, the public agencies are increasingly active in making medical decisions without physician contribution;

THEREFORE, BE IT RESOLVED, that physicians as defined by the Nebraska Medical Practice Act, must actively remain the patient's advocate and exert pressure individually and through their organizations to retain control of medical decisions that further that goal.

All testimony heard by the Reference Committee relative to Resolution #1 was favorable and it is recommended that the resolution be adopted as printed.

MR. SPEAKER, I MOVE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #4 - SCOTTS BLUFF COUNTY MEDICAL SOCIETY - NMA/PRO RELATIONSHIP

This resolution reads as follows:

WHEREAS, medical PRO in the State of Nebraska has caused deterioration in physician/patient relationships, and

WHEREAS, the administration of the PRO by our own medical society produces an inconsistency which cannot be adequately explained to patients;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association discontinue its function as administrator of PRO in the State of Nebraska.

The Reference Committee heard considerable testimony relative to Resolution #4. During this testimony, it became apparent that the resolution itself is technically inaccurate in that the Nebraska Medical Association is not the administrator of the PRO in the State of Nebraska. It was pointed out that the administrator is the Nebraska Foundation for Medical Care, and while the Foundation was originally established by the Nebraska Medical Association, it has a separate board of directors and enjoys an independent status.

In discussing the resolution, the concept of PRO was again considered. Those individuals in support of the resolution pointed out that physicians may not wish to be associated with the Nebraska Medical Association because of its perceived involvement with the PRO when physicians have disagreements with the PRO. It was also pointed out that there may be legal entanglements between physicians acting on behalf of the PRO and practicing physicians which could jeopardize relationships with the Nebraska Medical Association. It was further pointed out that the Nebraska Hospital Association has many complaints against the PRO which could jeopardize that relationship with the Nebraska Medical Association.

Those individuals testifying in opposition to the resolution pointed out that because of government edict that the concept of PRO is here to stay. The NFMC as a physician-sponsored organization allows the opportunity to review potential problems and disagreements on an advocacy basis rather than an adversary basis. While conceding that perhaps in its first year of operation some legitimate questions have been raised and some problems have existed, nevertheless it would be more productive and rewarding to improve the existing mechanism in as congenial a manner as possible rather than attempting to discontinue everything at this point. It was further pointed out that regardless of the administrative entity involved, local physicians would still be required to review other local physicians and therefore potential legal entanglements could not be avoided by having the NFMC be removed from its administrative role. It was announced that the NMA's Commission on Medical Services is charged with the function of reviewing PRO activities. This represents another avenue for the expression of grievances which should be made known to all members of the NMA. It was felt appropriate that the members of this Commission should not be directly involved in the activities of the PRO.

RECOMMENDATIONS:

In view of the technical discrepancy in the submitted resolution and after discussion with representatives of the Scotts Bluff County Medical Society, the submitted Resolution #4 will be withdrawn. The Reference Committee does not feel it proper to make a substitute resolution on its own at this time.

The Reference Committee further recommends that the NMA Board of Directors address the need to have better publicity relative to the PRO presented to the membership. This is particularly relevant to those points showing separation between the NMA and the NFMC and to those points relative to redress of grievance procedures both within the NFMC and the NMA.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded, and discussion followed concerning the grievance which prompted the introduction of this resolution. Dr. Gogela suggested that the PRO should contact the physician regarding the case before making its decision. This section of the Reference Committee report was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF THE REFERENCE COMMITTEE #3 AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Craig Urbauer, M.D., Lincoln - Chairman
John Fitzgibbons, M.D., Omaha
Robert C. Anderson, M.D., Holdrege

Reference Committee #4

Reference Committee #4 considered four reports. The Reference Committee submits the following report and recommendations. All of the reports reviewed dealt with medical liability problems. There was good attendance at the meeting with very extensive discussion. There were no adverse comments on the reports but they served as a stimulus for discussion.

Discussion started with the question of "who is going to deliver the babies?" It was pointed out that each year one out of every four physicians delivering babies will be sued and as a consequence, it will not be financially feasible to deliver babies.

It was pointed out that medical liability is the main topic of medical discussions nationwide and that although we have a sheltered environment here in Nebraska, we do have an ever increasing problem.

Lack of awareness of our problem on the part of the public is a big factor. There seems to be apathy on the public's part as to what doctors pay for medical liability insurance, in fact, they do not care. It was suggested that it may be necessary to restrict service in order to get their attention.

Recent changes in statutes of limitations making one liable for minors until they reach the legal age and insane people until they are recovered is difficult for doctors to cope with. A plea was made to establish time limits that are reasonable.

Child brain damage is a frequent source of law suits. It was pointed out that there is much confirming evidence that this damage may occur in utero and the same is true of congenital defects and the public should be made aware of these facts rather than blaming the delivery procedures.

In the rapid advancement of highly technical procedures, especially in oncology, there is a difficulty in conveying a complete and understandable informed consent. It was suggested that an adequate informed consent convey the two extremes of possible results such as in the case of surgery, some minor post-operative bleeding, to the possible death and not dwell on the myriad of possibilities in between that tend to confuse the patient.

Some concern was expressed about young doctors coming out of residency programs and not being informed of the medical liability problems and how their recent training does not equate with the type of practice of long standing especially in some of the smaller communities. These young doctors find themselves ready to testify in court without the background of experience out in practice. A problem also exists with the traveling expert who is unethical and willing to testify for a price.

As the discussion proceeded, it became obvious that it will be necessary to get the patient to share in the responsibility of getting well and that the doctor cannot carry the entire responsibility.

RECOMMENDATIONS:

(1) We should make a united effort to get further changes in our tort laws, not just a reform and we might start by eliminating general damages awards, i.e., for pain and suffering. This kind of tort change will necessitate the involvement of the public and they should be as the present situation and tort problems is involving all the professions and businesses.

(2) The second recommendation is that we must continue high quality medical care and police ourselves in order to maintain that quality.

(3) We recommend acceptance of the Report AAA and Report OO of the Board of Trustees of the AMA.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Following discussion, it was moved that a portion of Recommendation #1 be deleted to read as follows: "We should make a united effort to get further changes in our tort laws. This kind of tort change will necessitate the involvement of the public, and they should be, as the present situation and tort problems are involving all the professions and businesses." This was approved by the House.

This section of the Reference Committee report was adopted as amended.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #4 AS A WHOLE AS AMENDED. This was adopted by the House.

Respectfully submitted,
Arnold W. Lempka, M.D., Omaha - Chairman
Stanley F. Nabity, M.D., Grand Island
R. R. Andersen, M.D., Nehawka

Reference Committee #5

Reference Committee #5 considered four reports and one resolution. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE DEPARTMENT OF HEALTH - DR. WRIGHT

The excellent report of Dr. Wright was reviewed and considered. In relation to the block grant process, and also in consideration of the items regarding pesticide poisoning, it was suggested that one of the items to be considered was the continuing emphasis on education of children regarding accidental pesticide poisoning. The Committee also commends Dr. Wright for his support of the seat belt utilization and would like to encourage him to continue his support of the use of seat belts and to have the Nebraska Medical Association lend its support to continued implementation of the law. Statistics presented in Dr. Wright's verbal report should be well publicized throughout the State.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

The report was reviewed by the Committee and their activities were reviewed. The recommendation of the Committee is that the NMA members continue to be encouraged to stay in contact with national, state and local representatives in order that the views of physicians receive consideration in health issues.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REPORT OF THE AD-HOC COMMITTEE ON LOW LEVEL RADIATION WASTE DISPOSAL

The report was reviewed. No recommendations were forthcoming.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) REQUEST OF FIFTY-YEAR PRACTITIONERS AND LIFE MEMBERSHIP REQUEST

The list of Fifty-Year Practitioners was reviewed. The supporting documents were available to the Committee. It is therefore recommended that the Fifty-Year Practitioners be recognized at the 1986 Annual Session meeting as follows:

Hull A Cook, M.D., Sidney
John O. Milligan, M.D., Fremont
Charles M. Coe, M.D., Wakefield
McCleery Glazier, M.D., Laguna Hills, Calif.
Howard E. Mitchell, M.D., Lincoln
George T. Alliband, M.D., Omaha
Maurice L. Pepper, M.D., Omaha
Kenneth E. Pletcher, M.D., Bellevue
Herbert D. Kuper, M.D., Columbus
Robert E. Karrer, M.D., York

The second recommendation is that the Life Membership request for Dr. Leonard Lee be approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #6 - LANCASTER COUNTY MEDICAL SOCIETY - HEALTH CARE DELIVERY OPTIONS

This resolution reads as follows:

WHEREAS, the citizens of Nebraska, through various advertising media, are being deluged to purchase a variety of health care option, and

WHEREAS, insurance companies advertisements tend to focus mainly on the positive features of their insurance package, and

WHEREAS, it is important that all citizens of Nebraska understand the pros and cons of various health care delivery options;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association prepare an educational package available to citizens of Nebraska which defines the various types of health care delivery options and identifies the pros and cons of these systems.

Considerable testimony was heard in relation to this resolution which addresses itself to the provision of public education by the Nebraska Medical Association regarding the pros and cons of various types of health care delivery options. In regard to this matter, it was testified that the Lancaster County Society has had numerous inquiries from individuals wishing more information on choosing among the numerous health care options which are now being promoted within the communities of our state. The provision of a well-balanced summary of the options and choices is a goal to be desired and to this end, the American Society of Internal Medicine has published a brochure entitled, "Understanding and Choosing Your Health Insurance." This brochure is available at NMA Headquarters in packets of 25 for about 26¢ a piece. The cost of preparation of such a brochure by the NMA appears to be prohibitive. On the other hand, the Committee members felt that **quality** of medical care needs to be addressed as well as cost of medical care and further that the current advertising by health insurance providers is not stressing quality but is stressing bottom line costs, at times at the expense of the patient's health coverage.

In view of the factors as noted, the Committee recommends that the members be informed of the availability of the pamphlet on "Understanding and Choosing Your Health Insurance" and that members be encouraged to purchase these items from the NMA Headquarters and provide them to individuals who have a need to know in order to provide a balanced basis on which to make an informed decision.

The Reference Committee recommends an editorial change that specifies Resolution #6 be accepted with implementation being use of the ASIM produced brochure.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF THE REFERENCE COMMITTEE #5 AS A WHOLE AND I WISH TO THANK DR. RICHARD FORSMAN AND DR. GEORGE VOIGTLANDER FOR THEIR ASSISTANCE IN THE WORK OF THIS COMMITTEE. This was adopted by the House.

Respectfully submitted,
Gordon Adams, M.D., Norfolk - Chairman
Richard O. Forsman, M.D., Omaha
George Voigtlander, M.D., Pawnee City

Reference Committee #6

Reference Committee #6 considered four reports and one resolution. The Reference Committee submits the following report and recommendations.

(1) REPORT OF CREIGHTON UNIVERSITY SCHOOL OF MEDCINE, DR. O'BRIEN

We recommend that the report be accepted as written and note that comments are impressive.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(2) REPORT OF THE COMMITTEE ON HEALTH PLANNING

The second item taken by the Reference Committee was acceptance and review of the report of the Committee on Health Planning. The discussion centered around the theme that medical societies continue to participate in such conferences as ethics and rationing of health and medical care. We should keep informed and constantly be aware of the vast implications because of our responsibility as the patient's advocate. The Committee recommends the NMA pledge $500 to cover expenses of Dr. Henikoff, who will be a speaker at the program on October 24. He is a member of the AMA's Council on Ethical and Judicial Affairs.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(3) REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

The next item considered was to receive the report of the Ad-Hoc Committee on Health Education. The discussion noted that this Committee is becoming active and will be meeting more regularly in the future. We accept this report as written.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(4) REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

The Committee reviewed the report of the Commission on Association Affairs. This was reviewed and discussion chiefly involved Item #3 on membership of osteopathic physicians in the NMA. Our recommendation is that this report be accepted as written, and we further recommend the changes as written noting particularly Item #3, in reference to osteopathic physician membership in the Nebraska Medical Association.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(5) RESOLUTION #7 - LINCOLN COUNTY MEDICAL SOCIETY - MEDICAL SUPERINTENDENTSHIP OF THE LINCOLN REGIONAL CENTER

This resolution reads as follows:

WHEREAS, traditionally, the Superintendent of the Regional Centers has been a physician specializing in psychiatry, and

WHEREAS, the current Superintendent, Klaus Hartmann, M.D., has demonstrated all the necessary clinical and administrative skills to carry out such a position and is board certified in these areas, and

WHEREAS, the Department of Public Institutions has decided without apparent good cause to replace the psychiatrist Superintendent with an individual who is neither a physician/psychiatrist nor an acknowledged hospital administrator or possessing such skills;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association Board of Directors and the Nebraska Psychiatric Society liaison committee investigate the matter and resolve it such that medical judgment continue to be exercised on all clinical matters and that purely administrative matters be delegated to an administrator with an M.B.A. or similar credentials and the necessary experience in administration.

The final consideration of our Reference Committee was the resolution from Lincoln County Medical Society, Resolution #7. Considerable discussion was generated. This seems to be a management problem with medical concerns. Comments by Dr. Smith and others who were present did a very good job to clarify the medical relationships and structure of organization in the mental health institutions of the state. This Committee recommends that the Nebraska Medical Association Board of Directors in consultation with the Nebraska Psychiatric Society's ad-hoc committee investigate the matter and resolve it such that medical judgment continue to be exercised in all clinical matters and that purely administrative matters be delegated to an administrator.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #6 AS A WHOLE. This was adopted by the House.

Respectfully submitted,
Perry T. Williams, M.D., Omaha - Chairman
Robert Morgan, M.D., Alliance
Robert Osborne, M.D., Lincoln

There being no further business, the House was adjourned.

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AMA News Notes

(Continued from page 6A)

ance Claim Form for physician services, effective Oct. 1, 1986. Medicaid's adoption of the form at the national level means that physicians would have to stock only one form for at least three insurers. Medicaid and Medicare programs in several states already are using the form. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) uses the form, as does the U.S. Dept. of Labor for its federal workers' compensation program and black lung program. Many major insurance companies accept the form in their private lines of business. To obtain an order form, or to purchase the claim forms, write to AMA Insurance Form, Book and Pamphlet Fulfillment, P.O. Box 10946, Chicago, Ill. 60610. The telephone number is (312) 280-7168.

* * *

Market Area Profile Service of the AMA has received more than 3,000 inquiries from physicians since it was inaugurated last May. The MAP service provides physicians with detailed demographic and health resource data for existing or planned practice sites. Physician subscribers receive individualized, computer-generated data profiles on any area in the United States. The data profiles include 1980 census data, current year estimates, and five-year projections; data on the number, specialties, and ages of physicians in the area; and information on local hospitals.

* * *

Physician-To-Population ratio is expected to increase 17% by the year 2000. The 10-member Task Force on Physician Manpower, which the AMA Board of Trustees created in response to Substitute Resolution 47 (A-85), has concluded that a short-term increase in the number of practitioners relative to the population appears to be inevitable. Even dramatic changes, such as reducing the number of students entering medical school or barring foreign medical graduates from residency training in the United States, would have a limited impact on physician supply in the next 15 years. The Association's physician manpower policies will be reappraised at the 1986 Annual Meeting of the House of Delegates. The manpower task force, under the chairmanship of Charles N. Aswad, M.D., plans to complete its deliberations in time to guide the delegates' discussion.

* * *

Japanese Medical Professors met with AMA staff Oct. 4 to discuss possible changes in the training of physicians in their country. Since the beginning of the 1970's, Japanese medical schools have undergone a major expansion to meet an increasing demand for physicians. This demand is almost satisfied now, Hitoshi Osaki, director-general of the Japanese Bureau of Higher Education, said in correspondence with AMA officials. In the future, the government's attention will be focused on qualitative improvements. While visiting the AMA, the nine-member fact-finding team expressed an interest in the relationship of market forces and postgraduate training. Another concern was the influx of foreign medical graduates to Japan from other Asian nations, especially Korea and Vietnam, said Carlos J.M. Martini, M.D., vice president for medical education. Unlike western physicians, M.D.'s trained in Korea and Vietnam are able to learn the Japanese language easily and assimilate into the culture.

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April 25-28, 1985

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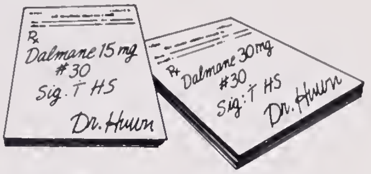

DALMANE®
flurazepam HCl/Roche Ⓘⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e g*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e g* excitement, stimulation and hyperactivity

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Dosage: Individualize for maximum beneficial effect. *Adults* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients* 15 mg recommended initially until response is determined

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl

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After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE®

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sleep that satisfies

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DUE IN 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

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